PUBLIC HEALTH NURSING

JUNE
1945

Effective, Convenient, Economical

THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solutions for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

Mercurochrome

H. W. & D. brand of merbromin, dibromoxymercurifluorescein-sodium

is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

Mercurochrome is antiseptic and relatively non-irritating and non-toxic in wounds.

Complete literature will be furnished on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland

PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Cooperation, Coordination, Amalgamation

"Resolved, that the NOPHN express its belief . . . that there be greater coordination of the public health nursing activities of voluntary and official agencies in each community . . . " This resolution was adopted at the 1944 Biennial.

It is obvious in the interest of complete public health nursing service, economically and efficiently given to all the people in every community, that there must be some kind of joint action between the agencies which offer services.

Never have there been either enough well qualified public health nurses or sufficient money for salaries to do the job that has to be done. In the current period of shortage of nurses, NOPHN has recorded its belief that wartime measures should be adopted for "pooling all field nurses giving direct service, and assigning each of them for general service in a given district. As a first step toward economy of personnel, direct services by a variety of specialized public health nurses should be eliminated."[1]

In many communities, coordination is still shockingly absent. In other places it exists in varying degrees. Some communities still have so many partial services that no amount of coordination could give a complete efficient service. In such cases, amalgamation of at least those services under private auspices is practical and reasonable. In other communities where there are only two or three agencies, careful planning for division of work and referral of cases between them may be all that is necessary. Sharing of staff education programs, consultant services, and office space are means through which coordination can be promoted.

Finally more and more frequently we are finding communities where all public health nursing service is pooled through the formation of combination agencies or by amalgamation into one. Thus the local health department may purchase all public health nursing service from a well established visiting nurse association or the health department may elect to give all the public health nursing service required in the community including bedside care of the sick in their homes.

The story of the year-old "Seattle Nursing Merger" as told by Dr. Ragnar Westman and Marguerite Prindiville (page 294) describes the amalgamation of an official and a nonofficial agency. If two agencies with such divergent administration machinery can find a way to combine their services, certainly agencies in similar communities might examine their own possibilities for joint action to provide first quality service with a minimum of personnel. The first step is an analysis of public health nursing requirements in the community with all agencies administering public health nursing participating. Gaps in services, overlapping, and ways of working together will be revealed. After such an analysis, all possibilities for working together which will ensure the most economical use of public health nursing personnel should be considered. Experimental measures can be tried for a temporary period and the agency can return to its former status if results prove unsatisfactory.

Those responsible for the administration of public health nursing know the service problems in their individual communities. Where there is need for overhauling and vigorous action, is there not a pioneer spirit to initiate the first steps toward complete cooperation, coordination, or amalgamation?

[1] "Maintaining Minimum Public Health Nursing in Wartime." PUBLIC HEALTH NURSING, December 1942.

Maternity and Infant Care

WHILE our country's maternal and infant mortality rates have fallen steadily over a period of years, rates have not yet reached their irreducible minimum. Examination of causes reveals that a large proportion of deaths are preventable. Field studies show that services are uneven in quality in separate communities, that gaps exist, that coordination is lacking between agencies concerned with care.

Four articles in PUBLIC HEALTH NURSING stress problems and programs. In May, Dr. Schmidt and Miss Brackett described the overall working of the EMIC program, Miss Turner following with a story of how a city VNA fits into the program. In the present issue, Miss Corbin points out the need for a *master plan*, quickly and skillfully put into operation; Dr. Williams shows that a county health department can give high quality maternity service as part of a generalized service.

That the successful operation of any "plan" depends on the adequate preparation of enough qualified personnel was one among several conclusions reached by the NOPHN Council on Maternity and Child Health which met May 28 with William M. Schmidt, M.D. as chairman. The Council expressed itself as believing that a great need exists for advanced preparation of public health nurses for this field, for executive, consultant and supervisory positions and that the whole matter of advanced courses and clinical experience needs to be explored.

The Council's meeting was its first in ten years, communication between Council members in the past having been via the mails if and when problems arose. The Council will now be a working body —with a plan.

The Armed Forces Have Enough Nurses!

THE news that military requirements for nurses have been met will fill every nurse in the country with a feeling of quiet satisfaction and self-congratulation, for there is hardly a nurse who has not had a part in the effort to achieve this end. Together with an expression of the thanks which the nursing profession as a whole accords the countless individuals, committees, and agencies which contributed to the four-year military recruitment effort, the situation is summed up in a letter from Elmira B. Wickenden, executive secretary, National Nursing Council for War Service, to state and local councils:

You will be relieved and happy to learn that the Surgeon General of the Army has notified the American Red Cross and the Procurement and Assignment Service that "the Army Nurse Corps is of sufficient strength at this time to assure adequate care of our soldiers."

The Acting Secretary of War has notified Congress, through a letter to Senator Elbert D. Thomas, Chairman of the Senate Committee on Military Affairs, that draft legislation can be dropped.

A few weeks ago, the Navy announced that the Navy Nurse Corps had filled its quota.

One of our goals has thus been reached at last—to meet the needs of the armed forces.

The Red Cross has notified area offices, and Procurement and Assignment Service its state committees, instructing them to discontinue active military recruitment. U. S. Cadet Nurses will furnish—from those who have served as Senior Cadets in Army hospitals—replacements for attrition and for unexpected future needs.

It is hard to find words to express adequately the gratitude that is felt on all sides to the state and local groups—Nursing Councils, Procurement and Assignment Committees, Red Cross Committees, and all others—for their faithful and unremitting labors over the last four years in recruiting and sharing nurses for the Army and Navy, and in carrying the heavy responsibilities of civilian nursing.

We still have problems, but the opportunity to put more of our time and resources into solving them may bring quicker results than we anticipated.

We must still meet our quota of 60,000 new students.

We must still meet the growing needs of the Veterans Administration.

We must make better distribution of our nurses on the home front. P and AS committees can now concentrate on their second responsibility—civilian nursing needs.

Now begins the difficult but constructive process, not of getting *back* to normal, but of going *forward* to something better than normal.

Safe Maternity for All

By HAZEL CORBIN, R.N.

IT IS the winter of 1918. America has mobilized an army to fight the Kaiser. Several million men are already overseas, leaving behind tearful wives and broken families. War has always done that. Our men left behind thousands of wives expecting babies. They had to eke out a meager existence on their soldier husbands' diminutive pay checks, frequently months late. As for good maternity care—that was out of the question unless some patriotic-minded doctor offered charity. There was no plan for providing maternity care for these women.

The effect of this knowledge on the men at the fighting front depressed their morale and caused many a man sleepless hours wondering what was happening at home.

I remember those days for I was a nurse in the district and it was the very first year of the Maternity Center Association. I visited many of these soldiers' wives. Some were ill of preventable diseases, all were anxious and perturbed at a time in life when they should have been expectant and happy.

We did our best to get them care. We summoned our courage many times to ask a doctor to give more charity care than we knew he could afford. Incidentally, the maternal mortality that winter was the highest in modern history.

I tell you this because it is good to contrast that depressing situation with the situation among the wives of the men in the Armed Forces today. Now in 1945, with millions of our men away, with hospitals over-taxed, with 60,000 doctors and 51,000 nurses serving in the Armed Forces, with the high wartime birth rate, the maternal mortality is at the lowest point in our recorded history. The times are equally perilous but the men across the seas, at Bastogne, the Maas, the Rhine, in the Philippines, New Guinea, in the skies over Berlin and Tokyo, have one worry off their minds. They know that their wives are getting maternity care. They know that all the bills are paid. This different situation is made possible through the Emergency Maternity and Infant Care Program, with money provided by Congress and administered by state and local health departments. The fees provided by this program are not so high as those charged by most doctors for obstetric care, but thousands of doctors who are caring for these women consider the difference between what the Government pays and their usual charge as part of their contribution to victory. The spirit with which they are caring for the wives of men in the Armed Services under the EMIC program is symbolized by the remark made by one doctor who said, "After all *I* can't fight in this war. It will give me a great deal of satisfaction to know that I am taking care of the wives of some of those men who are fighting. Send along as many as want to come to me. When there are too many, I will let you know."

The EMIC program has been under attack by various groups. Many of these attacks have been motivated by the fear that it is one more step toward socialized medicine. Those who fear the EMIC program for this reason should keep in mind that it is a device to pay the doctor and hospital rather than a system under which medical care is provided. It has done that job well. It has paid the bills. It has bought the care that is available, care

Miss Corbin is general director, Maternity Center Association, New York, N. Y.

which many of these women could never have afforded without this assistance.

The chaos which developed in New York following the passage of the law, when expectant mothers went from doctor to doctor, from hospital to hospital, vainly seeking care, largely resulted from a lack of information on how the EMIC program worked. Then, as now, no doctor, no hospital is forced to take the wives of soldiers under the EMIC program; no soldier's wife has to accept care under the plan. All is entirely voluntary, and this is as it should be.

To the New York City Health Department, to Commissioner Stebbins, Dr. Baumgartner and the staff of the Child Hygiene Bureau, right down to the last clerk, a great debt of gratitude is due for bringing order out of chaos quickly and efficently. Because of their zeal, every woman who applied got the care quickly and every hospital and doctor got the correct answers to a multitude of questions. They set the wheels in motion. They drew up a list of approved hospitals. They made the application blanks easily obtainable and cut whatever red tape stood in the way. They didn't think of office hours or of over-time pay. Their main thought was that these women must get care which they needed.

FOR THOSE who found difficulty in securing good care, or who didn't fit into the classifications prescribed by the law, Dr. Stebbins asked the Maternity Center Association to set up a consultation service. This we did. We immediately got in touch with doctors serving on obstetric staffs of hospitals on the approved list, to see if they would care for the wives of the men in the Armed Services for the small fee the Government paid. The large majority gladly agreed.

Many of the 10,000 women who have come to us during the past months were strangers in New York. They had followed their husbands from camp to camp, from coast to coast, and had bid them goodbye as they sailed for the fighting fronts. Some of these soldier husbands have been wounded; some are missing; some are dead. Their wives who came to the Maternity Center Association have all found practical and sympathetic help. When they leave our office after the first interview, they have a definite appointment with a doctor or a hospital clinic. Their foremost problem, that of securing care and paying for it, is resolved at once. Many of these women have other problems with which they need help.

One expectant mother, living alone, found that she couldn't make both ends meet on her husband's allotment. If she only knew another soldier's wife with whom she could share living expenses! We found another woman just like herself—and her problem was solved.

Another expectant mother was afraid of living alone in New York City. A room was found for her with a private family and she felt secure.

A good looking couple came with a most urgent request. The husband, a sailor in the Navy, was leaving his wife in a few hours, to sail from an Atlantic port. They wanted to know where they could get a pregnancy test. He said, "I must know if I am to be an expectant father before I sail. Out there on long watches I'll dream about the little fellow." He said that he could call his wife from his port of embarkation to learn the results. Ordinarily this would have been a simple enough request, but it was a holiday week end and the laboratories were all closed. However, we did arrange for the test, and when the husband called just before leaving these shores, he learned that he was indeed to be a father.

Many of the women who came to us for advice in selecting a doctor and a hospital signed up for our classes for expectant mothers. Here they learned how to care for themselves and their babies and how to fit their babies into their homes, so badly dislocated by the war. Here, too, they met other women in the same situation and many new friendships have sprung up which help to dispel loneliness and create a new feeling of confidence and security.

The problems of some mothers required the assistance of other social and health agencies in the city, who were unstinted in their efforts to help wherever and whenever possible.

This close working together of all, the doctors, the nurses, the hospitals, the Maternity Center Association and other social and health agencies in the city, under the leadership of our Health Department—

that the wives of men in the Armed Services might get good maternity care—is something in which every citizen in New York can take pride.

If the EMIC program has done anything, it has shown us the utter lack of a plan for maternity care for all on the basis of medical need. It has turned the spotlight on our hit or miss, catch as catch can, willy nilly arrangements for maternity care.

TODAY'S CARE for the wives of men in the Armed Forces is so much broader and better than it was in 1918, when little prenatal care was available and even fewer facilities for follow-up care, that we can easily become complacent about the state of maternity care generally throughout the country. Yet how uneven and incomplete is even the best care! In Community A, there is a hospital but no prenatal clinic. Mothers are dismissed with their babies from 24 to 48 hours after delivery. In Community B, there is no hospital. Most mothers are cared for by general practitioners with no access to specialists. These doctors do their best, and often their best is excellent. Too frequently, however, there is needless death, injury or suffering because, when abnormalities and difficulties arise, there is no expert consultation service. In Community C, there is marvelous prenatal care, consultation with tuberculosis, heart and related services, and the mothers get the very best of care, but after the baby comes they are dismissed from the hospital to whatever they call home—where no help is available. In Community D, there is no doctor, no hospital, no public health nurse.

Many of our American cities, towns and villages have a plethora of social and health agencies designed to care for this group and that. In one town there may be a visiting nursing association to which all of the community leaders give their time, efforts and energies. In another the tuberculosis association, because of its excellent program, commands the interest of the community leaders, in another the birth control clinic; in another the campaign against infantile paralysis, in another the old ladies' home. Many of these organizations provide complete care in their specialty. But one little plan heaped upon another little plan, devised to improve this segment or that in public health, heaps confusion upon confusion. In this manner the group with the loudest voice wins public favor, regardless of the need or relative importance of the service offered.

IF THERE is one word which epitomizes this lack of coordination of community facilities, that word is discrimination. Sometimes facilities in a community discriminate against the poor because they cost more than the poor can pay. Some low cost housing projects, for instance, designed for the poor, are rapidly filled by the middle class group because the cost is more than the poor can afford. Other facilities discriminate even against the rich. Classes for expectant mothers, for instance, designed to teach the essentials of safe care, the fundamentals of fitting the baby into the home, psychologically as well as physically, the problems of parenthood, are frequently held only in neighborhoods where those in the lower income levels live. Mothers in the white collar level and even in the highest income groups are eager for information. When classes are held where they are accessible and teachers are well prepared, there is always a large demand.

In some communities the rich and poor receive the best care that is available, the rich by paying the highest prices and the poor through free or low cost service. The middle class is discriminated against because they can't pay the prices the rich can afford and they are not eligible for the clinic care provided for the poor. They must take what they can pay for, even though they know it is of a much lower standard than that provided for the poor. Sometimes good obstetric facilities are denied various minority groups.

In these days of mounting war casualties and falling birth rates, the value of each new life is taking on a new importance. In the English speaking world, governments and groups of progressive leaders are working out ways and means to protect every new life, to nourish and

strengthen it, that it may contribute its best to its country.

Canada has recently enacted a family allowances law, following the lead of New Zealand and Australia. It provides a monthly sum to be paid by the government to the parents or guardians of every child under sixteen. This money must be used for the health and welfare of the child.

In England, the Royal College of Obstetricians and Gynecologists has recently proposed a plan for providing complete obstetric care to every mother and baby. The scope of the plan devised by this realistic group of leaders in English medical thought indicates how maternity care has broadened in the past decade. Nothing is omitted, from the teaching of young people the facts that will make the coming of their babies joyful events in their family life to the establishment of rest homes where mothers can go with their babies after they leave the hospital. These English medical leaders propose the establishment of a system of maternity centers providing every facility for consultation, diagnosis and treatment.

THE EFFORTS of Canada, Australia, New Zealand, England and other countries to devise plans which protect the life and promote the health of mothers and babies find echoes in this country but up to now no correlated plan has been proposed either in local communities or on a state wide or national basis.

We hold no brief for the plans of other countries. Our traditions and our methods for providing maternity care are different. But these programs in other countries indicate the need for a well thought through plan in this country, a plan which does not look upon complete care solely in terms of doctors and nurses, hospital beds, bricks and mortar. Complete maternity care is more than good medical, hospital and nursing care for the nine months before and three months after the baby comes. It depends upon knowledge and attitudes, on health habits, on mutual understanding of husband and wife, on the development of sound family living. The progress we are making in this country in teaching young people these facts is so slow that we dare scarcely call it progress. Taboos and prejudices in the minds of parents and educators, the lack of knowledge in the teachers themselves, the lack of good teaching material, the lack of courage on the part of school boards, all these have played a part in keeping the lid down on the true facts and in forcing young people to learn wh ever they can from their friends and acq aintances, who at best are poorly informed.

A sound plan for providing good mater y care to all depends upon an inform l public. This country has been disturbed by the blackout of news on the fighting fronts and has felt quite dissatisfied about the lateness of war news that is only 36 hours old. Yet we permit the blackout of facts in our schools about human biology, how a baby is conceived, grows within its mother's body and is born, and all of the related facts about the effect of the coming of babies on family life.

What is needed then is a joining together of all the thinking so that complete care may be available for everybody, from the teaching of young people the facts about marriage to pre-marriage counseling, to complete prenatal care, complete delivery care and postpartal care, health supervision of mother and baby, convalescent care, and housekeeping services. This should be part of a general plan to provide medical, nursing and hospital care for all.

In devising a plan to provide care for we must put aside traditions and prejudices, group interest and political logrolling. The place of the United States in the world to come depends to a great extent on the strength and vigor and numbers of our next generation. The lack of a plan for maternity care has already brought death to many mothers and babies, needless injury and suffering to many more, worry at one of life's most beautiful moments. The lack of a plan forces many a mother, otherwise self-supporting, to ask for charity. It causes many a doctor to give more free care than he can afford. The lack of a plan often

provides the best of care to those who need it least and the worst of care or no care at all to those who need it most.

These are days of social ferment and of change. If we, doctors, nurses, health officers, educators and civic leaders—all citizens of the United States—fail in our responsibility to devise a plan for safe care for all, then we must expect that a plan will be formulated by others less experienced and less informed. The only way to progress is for all the professions, with leaders in civic life and with Government, to plan and work together. This is our opportunity. The time is now.

Paper presented at the Twenty-seventh Annual Meeting of Maternity Center Association, New York City, January 19, 1945.

A One-Day Institute for Volunteers

THE Junior Volunteer Service Committee of the Scranton Visiting Nurse Association held a one-day institute on February 16, 1945, in order to introduce their work to prospective members and to provide a refresher course for their present membership. Each person was given a mimeographed copy of an excerpt from Mary S. Gardner's book on general principles governing volunteer service in public health agencies.*

The Institute was divided into two sessions, one afternoon and the other evening, with a dinner for the 42 members present. The afternoon session was opened by the Association president who gave a history of the Committee's activities for the past 22 years, followed by an informal discussion of the volunteer program. This included an interpretation of the basic philosophy of social work by the Association mental hygiene consultant who spoke on "The Art of Helping People Help Themselves."

As an added attraction a pre-test was given to everyone present, consisting of eight basic questions on volunteer work. This proved very worth while and caused interest and comment. Before the close of the afternoon session the director of the Visiting Nurse Association discussed the family case records and case histories used by the Visiting Nurse Association staff, and stressed their importance as a tool in maintaining close cooperation with other agencies.

An innovation was planned for the evening program when by "work-shop" method the group discussed problems and planned new activities for the coming year. Volunteers divided into three groups, each with a volunteer leader, to discuss challenging subjects and work out their own phases of volunteer work.

The first group studied "The Volunteer in the Well Baby Conference," with members of the Board of Directors and a professional member of the staff as resource persons. This group summarized the way in which the volunteer may relieve the nurse at such a clinic.

The second group discussed "Know Your Organization and Your Community," with the mental hygiene consultant, the Junior Volunteer Service Committee adviser from the Visiting Nurse Association Board and a member of the staff as resource persons. This group emphasized the value of progressive experience so that the new volunteer may be well acquainted with the organization before taking on responsibility.

The third group discussed "The Volunteer-Nurse Relationship and the Volunteer in the Office," with a former Junior chairman, the Association presi-

(Continued on page 313)

*Gardner, Mary S. Public Health Nursing. The Macmillan Company, New York, third edition revised, 1937, p. 440.

The Seattle Nursing Merger

By RAGNAR T. WESTMAN, M.D., AND MARGUERITE PRINDIVILLE, R.N.

THE MERGER of the private visiting nurse association with the official health department in Seattle under a generalized nursing program, including bedside care, has proved to be a real success. We have purposely waited until now to be absolutely sure of this before describing our experience, despite numerous requests meanwhile for information.

At the time of assuming duty as acting commissioner of health in May 1943, I found that the official health department had 14 public health nurses, 3 public health nurse supervisors, 14 clinic nurses and 3 clinic supervisors, a total nursing staff of 34 positions. There was no director of nurses, and the nurses were divided by various divisions doing specialized nursing work. In the community there was also a private nursing agency called the Seattle Visiting Nurse Service which had a lay board of directors, a director of nurses, 17 public health nurses and 2 public health nurse supervisors, a total staff of 20 positions. The official health department was of course supported by tax funds, while the private agency was supported by contributions from the local Community Fund, contracts with insurance companies and fees collected.

In passing it should be stated that there is a third nursing group in the city, the public school nurses, with a staff of some 23 nurses, who have not been approached as yet to join the merger.

Only half of the private agency's work was bedside care, so that half the time the private agency was doing the same kind of public health work as the official health department. In addition to this duplication of work there were duplications in overhead and transportation costs, as well as much loss of time. Frequently nurses from these two agencies ran into one another in the same city block or patient's home. The population of the city had increased 40 percent in three years to an estimated total of 480,000 with an additional 120,000 living just outside the city limits. There was an acute shortage of nurses in the community which threatened to become continuously worse. It was quite evident that we had to make more effective use of the nursing power available if we were to provide adequate nursing service to the community during the years of the war and the uncertain years of peace to follow. The continued separate existence of the two nursing agencies was manifestly both costly and inefficient, and it naturally followed that the two should merge.

By the latter part of June 1943 both the board of the private agency and the City Council had agreed that a merger of the two agencies would be approved when all details had been worked out. The 1944 City budget submitted in July provided for the creation of a new Division of Public Health Nursing with the City paying part of the director's salary. The budget of the Visiting Nurse Service prepared a few months later likewise provided for the merger.

For several months there were numerous meetings with the private agency to work out the details of organization. The Community Fund thought it saw an opportunity to reduce its financial costs by having the City take over some of them, and for a time we were sympathetic to

Dr. Westman is Sr. Surgeon (R), U. S. Public Health Service and acting commissioner of health, City of Seattle, Washington. Miss Prindiville is director, Division of Public Health Nursing, City of Seattle and Seattle Visiting Nurse Service.

this point of view, but the City Council refused to accept a greater share of the load, for which we shall always be thankful. We are now convinced that it is exceedingly important in such a program that the private agency continue to maintain its identity and contribute substantially with funds in order to insure continued high standards of program, freedom from partisan politics, greater flexibility of operation and adequate community support and participation.

In December the City Council passed Ordinance No. 72977 and shortly thereafter a Memorandum of Agreement was signed, effecting the merger. Because of the widespread interest shown, we reproduce these documents in detail:

ORDINANCE No. 72977

AN ORDINANCE relating to the Department of Health and Sanitation; creating therein a Division of Public Health Nursing in aid of the preservation of the public health; allocating certain positions to such division, creating additional positions therein, and fixing the compensation thereof; creating a special fund and authorizing certain expenditures and commitments, all in connection with the expanded program of public health nursing service hereby contemplated.

BE IT ORDAINED BY THE CITY OF SEATTLE AS FOLLOWS:

Section 1. That effective January 1, 1944, there is hereby created in the Department of Health and Sanitation the Division of Public Health Nursing. All Public Health Nurses and Senior Public Health Nurses in said department shall be allocated to such division and the duties shall thereafter be the public health nursing work, including bedside care and related work, as required by the Commissioner of Health under this ordinance. All Nurses and Senior Nurses except those at Firland Sanatorium shall also be allocated to said division. The titles of all the positions so allocated shall remain unchanged.

Section 2. In addition to the existing personnel allocated by Section 1 hereof the following additional positions are hereby created in the Division of Public Health Nursing:

1 Director of Public Health Nursing
3 Senior Public Health Nurses
20 Public Health Nurses
1 Intermediate Clerk-Stenographer
5 Junior Clerks

All of the above newly created positions shall be filled in accordance with civil service laws and rules, and the salary rates of the additional positions of Senior Public Health Nurse, Public Health Nurse, Intermediate Clerk-Stenographer, and of Junior Clerk shall be the same as provided in the annual salary ordinance for such positions in the Department of Health and Sanitation: Provided, that the monthly salary of one such position of Senior Public Health Nurse shall be One Hundred Sixty Dollars ($160.00) plus Five Dollars ($5.00), and the monthly salary of the position of Director of Public Health Nursing shall be Two Hundred Eighty-five Dollars ($285.00).

In case of promotion, the salary shall be the next higher rate above that previously received, and automatic "step-ups" shall apply as to like positions for which provision is made in any annual general salary ordinance. There shall be added to all such salary rates any war bonus provided by ordinance.

Section 3. The duties of the Division of Public Health Nursing hereby created and of the personnel therein shall be those measures for the preservation of the public health commonly known as public health nursing work or service, including bedside nursing care. All such work or service, except bedside nursing care, shall be extended free to all residents within the City limits of Seattle. Bedside nursing care shall be extended free to those persons within the City limits of Seattle who are unable in the judgment of the Commissioner of Health to pay the fee hereinafter provided for. Bedside nursing care may, with the approval of the County Health Officer, be extended to areas abutting the City limits to 125th Street on the north and 112th Street on the south, under such regulations as may be prescribed by the Commissioner of Health, if the fee hereinafter provided is paid therefor. It is contemplated that fees shall be collected for bedside nursing care from patients able to pay therefor at such rates as the Commissioner of Health shall determine, based upon estimated cost of the visit. All fees collected shall be deposited in the special nursing fund hereinafter provided.

Section 4. It is contemplated that the Division of Public Health Nursing hereby created shall be financed for a time by gifts and donations, plus such fees for service mentioned in Section 3 as may be collectible and such Budget items as may be available therefor. Moneys donated and gifts made shall be regarded as in trust for the purpose of the donation or gift.

Section 5. To carry out the purposes of this ordinance there is hereby created in the City Treasury a special fund to be known as "The Special Nursing Fund," into which shall be paid all the fees, donations and gifts above referred to and out of which shall be paid all expenses of the Division of Public Health Nursing not otherwise provided for, including for a time the salaries of all the positions newly created by this ordinance, and such salaries shall be paid solely from such fund except that a part of the Director of Public Health Nursing salary will be paid as provided in the budget of the Department of Health and Sanitation, and if such fees and donations are not sufficient for such purposes the service hereby contemplated shall be curtailed and the personnel reduced corre-

spondingly. The City Comptroller is hereby directed to draw and deliver and the City Treasurer to honor and pay warrants on the special fund hereby created in accordance with payrolls and for other expenditures of said division approved by the Commissioner of Health and by the Auditing Committee of the City. Moneys in such special fund shall be regarded as trust funds, shall be expended only for the purposes of this ordinance and shall not be transferred to the General Fund or to any other fund of the City.

Section 6. Furniture, supplies and equipment furnished by the Visiting Nurse Service in connection with this ordinance shall be inventoried and permanent articles of furniture and equipment shall remain its property, subject to use free of charge by the Division of Public Health Nursing.

Section 7. Authorization is hereby given the Commissioner of Health to establish decentralized Nursing Centers within the City limits of Seattle and to pay rent for such centers out of the Special Nursing Fund created by Section 5 hereof only, and subject to the approval by the City Council of the amount of such rent.

Section 8. (30 day ending)

Early in 1944 the acting commissioner of health and the board of the Visiting Nurse Service signed the following Memorandum of Agreement for the amalgamation:

Memorandum of Agreement

Between the Seattle Visiting Nurse Service and the Seattle Department of Health and Sanitation, creating a Division of Public Health Nursing by Amalgamation.

PURPOSE: To place on record the understanding between the Seattle Visiting Nurse Service and the Seattle Commissioner of Health governing the amalgamation of the personnel of the Visiting Nurse Service and the nurses of the Seattle Department of Health to form a new Division of Public Health Nursing in the Department of Health and Sanitation as authorized under City Ordinance No. 72977, approved December 7, 1943, so that the present and future Boards of Directors and Commissioners of Health may be guided thereby. It is understood that this agreement is not legally binding on either agency and may be changed from time to time in writing by mutual consent, and it is further understood that this agreement may be terminated at any time by either agency when and if it is felt that better nursing service can be provided the citizens of Seattle in some other manner.

BOARD OF DIRECTORS OF THE VISITING NURSE SERVICE

The Board of Directors of the Seattle Visiting Nurse Service shall continue to exist as a self-perpetuating board according to its Articles of Incorporation and its By-laws. The Seattle Visiting Nurse Service shall continue to maintain its identity, keep separate bank accounts, accept gifts and bequests, and the like. The Board of the Visiting Nurse Service shall act in an advisory capacity as the Advisory Board of the Division of Public Health Nursing, it being understood that decisions of the Commissioner of Health shall be final.

PERSONNEL OF THE VISITING NURSE SERVICE

The present Director of the Visiting Nurse Service shall be the Director of the Division of Public Health Nursing and the entire staff of public health nurses, clerks, and stenographers of the Visiting Nurse Service shall become City employees provided that the rules and regulations of the City Civil Service Commission are complied with, and will participate in all rights, privileges and benefits under Civil Service and Retirement rules and regulations, as are other City employees. The qualifications for these positions have been outlined by the Civil Service Commission.

ORDINANCE NO. 72977

Ordinance No. 72977 as approved December 7, 1943, is hereby incorporated into the agreement, and a copy of this ordinance is attached hereto.

FINANCIAL

The Commissioner of Health shall prepare an annual budget for the Division of Public Health Nursing, which shall be reviewed by the Board of the Visiting Nurse Service and submitted to the Community Fund for approval. The time for presenting City budgets to the City Council is about the first of July each year for the following calendar year. The Visiting Nurse Service will plan to assume a portion of the total budget as agreed upon, guided by Ordinance No. 72977, using contributions from the Community Fund subject to the outcome of the annual campaign, and Funds from other sources.

It is understood that whenever a vacancy occurs in the Division of Public Health Nursing in positions paid directly by the City (not out of the Special Nursing Fund), nurses and clerks in order of seniority being paid from the Special Nursing Fund shall be transferred to positions paid directly by the City. New employees will be paid at first from the Special Nursing Fund.

The Visiting Nurse Service, using Community Fund contributions and/or other sources of revenue, shall pay in advance monthly payments, such sums of money as are calculated to meet the expenses of the following month according to the agreed budget, the payments at the end of the year so calculated that there will be no excess amount of money in the Special Nursing Fund. Ordinance 72977 clearly states that all money placed in this Fund shall be regarded as trust funds, which the Visiting Nurse Service may claim should this agreement and amalgamation be terminated.

All cash money collected by nurses in the field, such as fees for bedside nursing care, shall be presented by the Director of Public Health Nursing to the Chief Clerk of the Department of Health and Sanitation, who shall deposit it into the Special Nursing Fund of the City Treasurer, keeping a record thereof for himself and the Visiting Nurse Service. This requirement is considered necessary because City employees must turn over all money collected to the City Treasurer. Receipts for cash shall bear the words "Seattle Visiting Nurse Service" in large bold characters and underneath in very small type "and The Seattle Department of Health and Sanitation." Bills to insurance companies, agencies, and individuals for bedside nursing care, shall have the same type of heading, the emphasis being on the Visiting Nurse Service to improve collections. All money received from these insurance companies, agencies, and individuals shall likewise be presented by the Visiting Nurse Service to the Chief Clerk of the Department of Health and Sanitation, who shall keep proper record and deposit the same in the Special Nursing Fund of the City Treasurer. The reason for this is much the same as for cash fees collected directly from patients by nurses. All other money received by the Visiting Nurse Service as contributions, gifts, bequests, and the like, from the Community Fund or other sources, shall be paid into the separate bank account of the Visiting Nurse Service at any bank it may choose.

The Visiting Nurse Service may at any time request and receive a statement of payments into and disbursements from the Special Nursing Fund, balance on hand, and so forth, which may be used in connection with the auditing of the books of the Visiting Nurse Service.

The Budget for the year 1944 and the years following, shall be agreed upon as separate agreements to be filed herewith.

The Visiting Nurse Service shall attach hereto a copy of an inventory taken at the time of amalgamation, which shall become a part of the agreement. All permanent articles, such as furniture and the like, shall remain the property of the Visiting Nurse Service, and shall be returned without compensation for wear and tear to the Visiting Nurse Service, in event this agreement is terminated. Expendible articles, wear and tear, and so forth, are considered as things which would be used up by the Visiting Nurse Service in the course of its work, even if there were no amalgamation. The Department of Health and Sanitation shall use the articles listed in the inventory without charge.

TRANSPORTATION

All home visiting nurses shall be furnished transportation under one of the following arrangements:

1. Use automobiles furnished by the Department of Health.

2. Use personal automobiles reimbursed at five cents a mile, or other rate determined from time to time by the City Council.

3. Nurses now receiving reimbursements at a flat monthly rate shall continue to be paid the same directly by the Visiting Nurse Service, according to an agreed budget.

4. New members of the staff shall be reimbursed for use of personal automobiles at the rate of five cents a mile, or other rate determined from time to time by the City Council.

All home visiting nurses driving automobiles must be insured for public liability, in the amount of $10,000 / $20,000, and the Seattle Visiting Nurse Service and the Seattle Department of Health, shall both be protected. All nurses may pay the premium through the Seattle Visiting Nurse Service in annual or quarterly payments to the insurance company to benefit from a group plan.

PROGRAM

Duties of the Division of Public Health Nursing personnel shall be those measures for the preservation of the public health commonly known as public health nursing services including bedside nursing care. They shall give skilled nursing care on an hourly or a visit basis to people in their homes under the direction of a licensed physician. The nurse visits for purpose of education or control of communicable disease, shall not be limited as to number, but when there is no physician responsible for treating the case the Nursing Director will review the case and limit the nursing visits to two for care of the patient.

The nurses in the field, will not dispense drugs beyond the written standing orders of the physician in charge of the case. On the nurse's first visit, when no physician is available, or in an emergency, the nurse may use the standing orders of the Medical Advisory Committee for one visit only.

This program will eventually become a completely generalized service, with each nurse assigned to a district, in which she will assume the responsibility for home visiting for every service.

PERSONNEL POLICIES

All nurses will work a 40-hour week as provided by City Ordinance but the time shall be arranged by the Director of Public Health Nursing. As far as possible, the plan is to be on duty at 8:00 A.M. to 5:00 P.M., five days a week, with 60 minutes lunch period, the sixth and seventh day of the week being off duty. These two days off duty, shall be assigned by the Director, and not necessarily on Saturday or Sunday, but on days during the week convenient to the program. Sundays and holidays will be covered by sufficient nurses to properly care for communicable diseases and critically ill patients. The Nurses will be available for Sunday and holiday work in alphabetical rotation. Nurse on call will come into the office of her district on Saturday afternoon to plan Sunday work.

The rules and regulations of the City and the Department of Health shall cover such items as

time accounting, holidays, vacation, and sick leave.

A standard uniform shall be adopted by the Commissioner of Health and the Director of Public Health Nursing, which each home visiting nurse shall procure as present uniforms wear out. Over the left breast of the uniform shall be sewed a tape reading "Seattle Department of Health," and just above this shall be worn a pin reading "Seattle V. N. S."

STUDENT PROGRAM

The Division of Public Health Nursing shall offer a student field training program for undergraduate and graduate students of public health at the University of Washington, the number of students to be decided by the Commissioner of Health, and the Director of Public Health Nursing.

The most important part of the arrangement was the payment of private funds into a Special Nursing Fund in the office of the City Treasurer, where such funds might be regarded technically as "City" funds to be disbursed by City checks, thereby making "City" nurses out of the private agency nurses, and so placing them under City Civil Service and retirement rules and benefits. In this way all nurses will be working under the same salary scale and all will have equal benefits, which is very important for harmony and stability. This is a very logical yet unusual arrangement. The Seattle Visiting Nurse Service continues to maintain its identity, its board of directors, its group of 400 lay workers organized into districts over the city. The private agency continues to make contracts with industries, insurance companies, and the like, which obviously the public agency cannot do.

The new central office for the Division of Public Health Nursing was not ready on January 1, 1944, as planned, so it was not until March 1 that the Seattle Visiting Nurse Service moved to the City Hall. Within a few months two decentralized nursing centers were established, one in the northern and one in the southern part of the city, but it was not until February 1945 that the fourth district office in west Seattle could be opened, there being such an acute shortage of houses here. Having these centers open slowly one after the other caused added work in moving nurses, equipment, and records, but it could not be avoided. As a postwar project the City Council intends to build luxurious nursing centers over the city. Each of these four nursing districts are subdivided into as many smaller districts as there are nurses. In her own little district each public health nurse does all the nursing work that is to be done, including bedside care. The specialized communicable disease service and the parochial school service of the health department were not generalized at once but are being gradually absorbed into the generalized program as personnel and preparation of nurses permit.

This merger was accomplished with surprisingly little friction or confusion, but it was a great deal of work. Numerous experts who have visited us have marveled that five years of progress could have been accomplished within a single year. It was cooperation that did it—everyone working together toward a common goal. A self-governing staff council of all nurses in the new Division of Public Health Nursing helped immeasurably to build up an esprit de corps.

We had our problems and troubles too. There was a shortage of automobiles and additional ones could not be bought, so some nurses had to move around on foot, which in hilly Seattle is time-consuming. The requirement that City automobiles had to be parked in a central garage was a hardship until it could be changed. A messenger service had to be set up to get records, supplies and collections to and from the various nursing offices. New fee receipt books, new billing systems, new ways for handling and depositing money, and new bookkeeping systems had to be prepared and adopted. A code for recording nurse visits and activities to give detailed statistical breakdowns was prepared, every visit being transferred to a punch-card. Early in 1945 we originated a mark-sensing system whereby nurses record visits by merely making pencil marks on individual punch-cards which are later automatically punched by electric machine. We have tried to streamline the nurse program in many ways, including reduction in the paper work required of nurses. It was simpler of course

to make changes under the generalized program by simply changing emphasis on various services; under the specialized service we would have had to change nurses themselves around. The generalized program is certainly more flexible.

One of the first steps of organization was the establishment of a personnel index listing the qualifications and experience of each nurse. We could then plan the program, making most effective use of the nurses available, and we could rotate nurses in various clinics and services so that eventually all would be equally well trained.

The shortage of nurses during wartime, one of the reasons for the merger, kept getting worse as the war progressed. The merger was therefore more difficult than it would have been in peacetime. At the time of the merger in March the private agency had only 12 public health nurses instead of the 17 of earlier date. The director of the private agency, a supervisor from each agency, and three nurses from the official agency decided to leave just before the merger to take better paying positions elsewhere or go into retirement. There was an almost continuous change of staff throughout the year, much of which was due to the impact of war on the stability of family life (husbands being transferred, et cetera), or there was discontent with the low salaries paid. There were relatively few who left because they did not like the combined service and the bedside care work. There were 34 positions of public health nurse in the combined budget, but we were able actually to employ only 20 to 28 at any one time and were always short an average of 11 nurses compared to the staffs before the merger. We employed 26 new public health nurses during the year, most being wives of servicemen who had just gone off to war, so that in effect we had 100 percent turnover of public health nurses. Only 7 of the original private agency and 8 of the official agency public health nurses remain. We made 11 replacements during the year among a staff of 14 graduate nurses for clinics, which was an almost 100 percent turnover. There was a complete turnover of clerical staff in the nursing division, clerks leaving soon after getting a little experience, to take higher paying positions elsewhere. Low salaries were definitely a problem for the nursing division, but the City Council is now about to increase salaries and establish a satisfactory salary scale with automatic increases.

These rapid turnovers and shortages of personnel have placed a tremendous teaching load upon those who stayed at their posts. Some of the staff had to be promoted to central supervisory responsibilities, and field supervisory positions had to be filled by staff with no previous supervisory experience. It was necessary to institute a complete supervisory educational program. Both a supervisor's and a field nurse's manual were written. Regular classes of instruction were set up for the nurses and supervisors. An educational director was added to the staff. The amount of teaching work that had to be done merely to train new personnel in the turnover was truly colossal.

The University of Washington had for a number of years used both agencies as a practice field for their basic students. Since the students received experience in only one agency or the other their training was naturally incomplete. The combined program has been able to extend this service to 13 new students every 6 weeks. The University is hopeful that we may soon be able to increase the number of students and extend the service to graduate nurses, but we must defer this until we have a full staff of experienced personnel. These students help a great deal in providing additional nursing service to the community while training, but at the same time they mean a great deal of educational work for the supervisors.

The Board of Directors of the private agency has carried on with flying colors. A new board manual was prepared and a series of lectures was given to acquaint the board members with the details of the new program, particularly with the enlarged horizon provided by the many divisions of the official health department. Through the printed word and pictures in newspapers and by means of radio talks the Board has interpreted the en-

larged program to its own members and the community at large. A volunteer committee of the Board has helped by working without pay in place of nurses and clerks in many of the clinics of the health department. The 400 members of the private agency, divided into 12 districts over the city, continued to make surgical dressings, layettes, and the like. In addition, most of them in groups have subscribed to the national PUBLIC HEALTH NURSING Magazine and attended regular monthly meetings at which special articles were discussed. A news letter for these lay members is also circulated.

Population increases in the community have naturally increased the work of the health department and the nurses in particular. Our small staff is tremendously overworked and the pressure of work threatens to engulf us. As we all know, the accepted ratio in peacetime is one nurse per 2,000 population and in wartime, one nurse per 5,000. In Seattle our ratio today is one nurse per 20,000 population.

All of our various clinics were overloaded. For example, the venereal disease clinic in 1944 had 11,000 more case visits and 7,000 more prediagnostic visits than in 1943. The nurses assisted at 7,000 more physical examinations, took 7,000 more blood tests, 7,000 more gonorrhea cultures, and 2,000 more gonorrhea smears than in 1943.

The combination program was established by merger to make more effective use of nursepower. A brief study of the statistics reveals that the challenge has been met. The two nursing agencies working separately before the merger made a combined total of 52,619 visits in 1943. After the merger a total of 52,043 visits were made in 1944. *We made the same number of field visits after the merger as before, despite the fact that we always had about one fourth fewer nurses, we had a 100 percent turnover of staff, and we had to take much time in teaching new personnel and working in clinics.* In other words, it would appear that the generalized program is perhaps 25 percent more effective than the specialized program in making use of available nursepower. This takes into account the fact that the private agency was also somewhat short of staff before the merger. The generalized program was found to be more flexible and more productive in results; it eliminated useless duplication and distance of travel.

Because of the ever increasing shortage of nurses in the community, it was early decided that we ought to eliminate the frills and instead do those things which were most important in saving and prolonging life. We therefore purposely reduced the number of visits to the chronically ill as much as possible, many of which had been made routinely, because we believed they were both unnecessary and wasteful of nurse time. Only for this reason did our number of bedside nursing visits fall from 50 percent of the total visits in 1943 to 36 percent in 1944. Maternity service visits increased 50 percent, especially antepartum visits, largely brought about by the EMIC program and shorter periods of hospital stay. The number of visits for the specialized fields, such as tuberculosis control, remained the same after the merger. A comparison of the program before and after the merger indicated that there was no loss in the quantity of work done for the specialized services, as so many fear in a generalized program. There was, perhaps, a slight decrease in quality of work done for the specialized services, but this we attribute to the tremendous shortage and turnover of nurses. Keeping up quality of work is always a challenge in any program, but particularly so in the beginning of a generalized program. When the extensive turnover of personnel stops and the staff becomes stabilized, quality will improve. The educational services of the nursing division to all age groups increased 100 percent, which certainly indicates that the prevention program maintained high standards, and the health department in particular benefited by the merger, getting more of its usual work done at less cost.

The financial classification of field visits as to pay, part-pay, and so forth, was exactly the same after, as before, the

merger, so that the combined program did not turn out to be a financial hazard as some had feared. It was true that the nurses from the official agency were not accustomed to collecting fees, and knew nothing about insurance company practices, but soon we found that they were doing as well as the private agency nurses in making collections. According to our statistics the nurses made one third fewer visits to insurance company clients, but we believe that more were actually made, credit not being obtained because of unfamiliarity with insurance forms and practices. At no time was there any shortage of funds and indeed there was a sizeable surplus at the end of the year, as would be expected from lapsing salaries in the reduced staff. The combined program has proved financially sound.

The merger has given more to the community than can be measured by statistics alone. It was like a marriage which brought new blood into the family, or like a transfusion which put more life into the body. The merger is the most important thing that has happened to public health in Seattle during the last 25 years, and its results will reach far into the future. It has taken the health department out of the doldrums where it had been a long time and has given it more enthusiasm and vigor, and has set up higher standards of performance. This merger has done more to modernize the health department than any other factor. Both the private and official agencies are exceedingly well pleased with the results. An opportunity has finally been given for the citizens to participate in a total health program with a common goal regardless of source of funds.

NURSE PLACEMENT SERVICE

NPS announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Ethel Kersey, B.S., nursing field representative, American Red Cross, North Atlantic Area, New York, N. Y.

*Maxine E. McCormick, district supervising nurse, State Department of Public Health, Gilman, Ill.

Mrs. Hilda K. Sutton, assistant school nurse, Tuberculosis Institute of Chicago and Cook County, Chicago, Ill.

Beatrice E. Freeman, staff nurse, Baltimore County Health Department, Towson, Md.

Loretto M. Crowe, industrial nurse, Chicago Rawhide Manufacturing Company, Chicago, Ill.

Mrs. Norma C. Pohling, industrial nurse, Ever Sharp, Incorporated, Chicago, Ill.

ASSISTED PLACEMENTS

*Kharis B. Mayers, assistant public health nursing consultant, United States Public Health Service (Tuberculosis Control Division) Washington, D. C.

*Ina B. Reynolds, B.S., educational supervisor, Baltimore County Health Department, Towson, Md.

*Florence M. Ehlers, B.S., supervisor (of Sussex County Health Unit), State Board of Health, Dover, Del.

*Mrs. Abbie L. Hunt, school nurse, Gary Public Schools, Gary, Ind.

---

*The NOPHN files show this nurse is a member.

The Small Industrial Health Unit

By HEIDE HENRIKSEN, R.N. AND L. W. FOKER, M.D.

IDEALLY an industrial health facility should be the result of joint planning by management, the physician, the nurse, and an architect experienced in the construction of hospitals and health centers. A unit thus designed will fill the specific needs of the plant. However, unified preplanning is not always practical. In the small plant or the building that has long been constructed, where space is at a premium, it becomes necessary to plan in terms of minimum essentials fitted into as small space as is practicable.

There are certain features that have been proved to be so desirable in industrial health units that they may be considered minimum essentials:

1. The basic industrial health unit consists of a minimum of three rooms—a treatment room, a rest room, and a toilet. The problem of providing a toilet in a building where the plumbing is already installed may be met by placing the other rooms adjacent to previously existing washroom and toilet.

2. Preferably, the health service should be situated on the first floor, with an exit that can be reached easily by automobile or at least a direct exit to a corridor leading to an automobile entrance. Considerable distraction to other employees occurs when a patient is assisted through the workroom, and the patient may experience unnecessary discomfort if he has to be taken by a circuitous route to a conveyance. If there is no space available on the first floor, accessibility to an elevator is essential.

3. It is desirable that the health service be adjacent to employment and personnel departments. Coordination of service is promoted when these departments are housed as a unit.

4. The health service should be accessible to workers. In the small, compact plant, one unit can fill this requirement; in the large plant, decentralization with small first-aid stations in strategic locations is to be preferred.

5. In hazardous occupations, the health service should be situated in a safe zone.

6. The rooms should have excellent light and controlled temperature and ventilation.

7. Freedom from noise and vibration is important. It is highly desirable that the rooms be sound-proofed if situated near noisy processes.

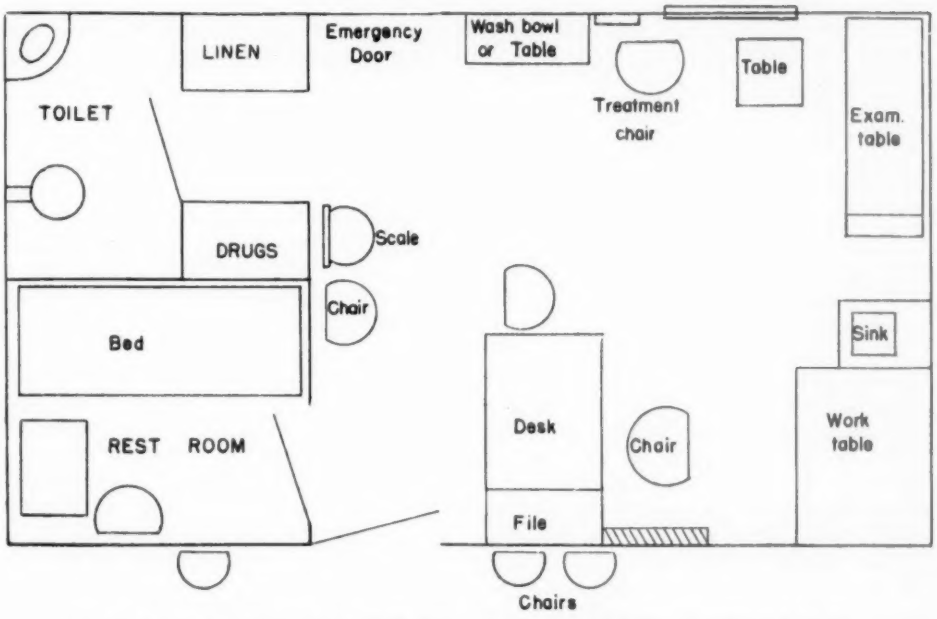
8. Expansion must be allowed for if possible. Frequently, the service which starts with a first-aid station expands to become a health service with a full-time medical director. As the medical department proves its worth, space for additional personnel and equipment for additional services such as x-ray or physiotherapy may be added to the original unit.

THE average health facility in the small industrial plant or business concern falls into one of two general patterns.

One is found in plants where the primary need is for emergency care of the injuries that occur in the process of production—lacerations, small splinters, foreign bodies in the eye, et cetera. For this type of service, the well equipped treatment room is the first essential.

The other type is found in those plants where the likelihood of injuries is remote and where most of the nurse's time is spent in health counselling, in assisting

Dr. Foker is director and Miss Henriksen, nursing consultant, of the Division of Industrial Health, Minnesota Department of Health.



PLAN NO. 1 A COMPACT HEALTH SERVICE UNIT (Scale approximately ¼" = 1')

with the preemployment and periodic physical examinations, and in the administration of services such as sick benefit associations, prepayment hospital plans, and the like. Primarily needed here is a functionally useful office. The treatment room is a necessary adjunct, but it is not the main workroom.

The following three schematic arrangements illustrate the above types of health unit and also one fitted into preallocated space.

In *Plan No. 1,* the treatment room is the main workroom. The essential pieces of furniture are centered near the best light and away from the plant entrance. The room is equipped to carry on all the essential services of a well rounded health program, with the exception of x-ray, physiotherapy, and complex laboratory tests. (See diagram, Plan No. 1.)

It is possible to take care of a considerable volume of work in this one small room. For instance, one worker seated in the main treatment chair may be having an injury dressed, while another, in the second chair, may be detained in a more time-consuming treatment such as a hand soak or hot pack. A third on the examining table behind a screen may be getting a lamp treatment.

The arrangement of equipment is based on the flow of work, the purpose being to conserve steps for the nurse and eliminate cross traffic between the nurse and incoming workers, protecting the "clean area" and reducing opportunities for contamination.

At the entrance is the nurse's desk where patients are registered, health histories taken, and reports of injuries recorded. Here the injured worker, as he enters, is met and directed to the sink to remove gross contamination, to the treatment chair, or to the rest room. The file cabinet adjacent to the desk facilitates the keeping of adequate records. The work space may hold at one end the tray for obtaining serological specimens, the microscope and a telebinocular type of visual testing apparatus. At the other end will be a small electric sterilizer. A shelf adjacent to the sink will have the necessary equipment for simple urinalysis. A refrigerating unit, placed beneath the work space, is practically indispensable in storing biologics and serological specimens awaiting collection, and in providing

ice when an ice pack is indicated. The examining table and a treatment chair with headrest and adjustable arm- and footrest are close to the window to utilize daylight. A sphygmomanometer is attached to the wall. A tank of compressed air may be connected to the sphygmomanometer. This reduces the time involved in blood pressure reading to the minimum, which is a factor to consider when many physical examinations are being made.

The second treatment chair, in addition to its obvious purpose in therapeutic procedure, is used in making tests of central visual acuity for distance; the necessary 20 feet are secured by the use of a mirror placed on the opposite wall.

The rest room can be used as a dressing room in certain instances, as for example, when the plant physician comes for only an hour a day and it is necessary to conserve time in order to complete a scheduled number of examinations.

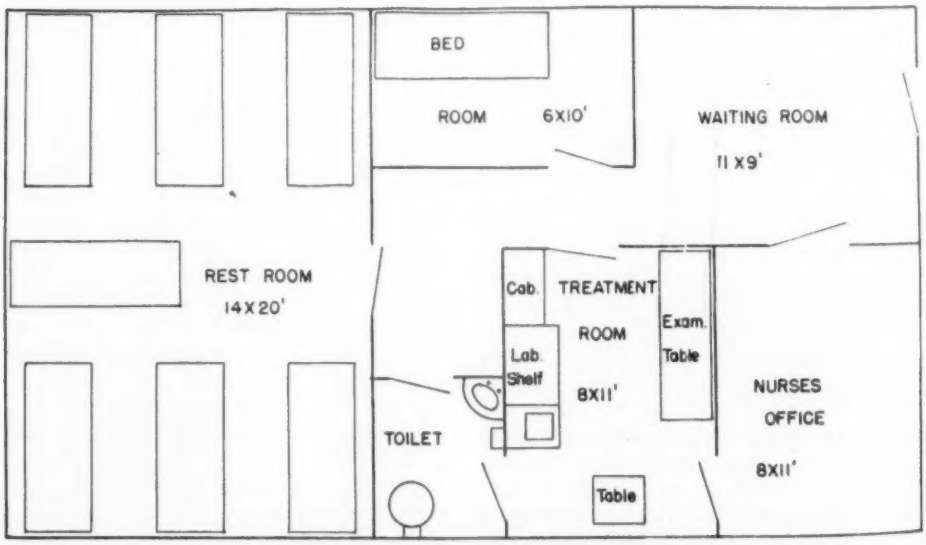
Maximum storage space is provided by placing cupboards above the work area and in other available space.

Chairs or benches may be placed outside, against the wall separating the health unit from the factory, for persons waiting for service or for preplacement examinations. This same wall is an excellent billboard for educational posters.

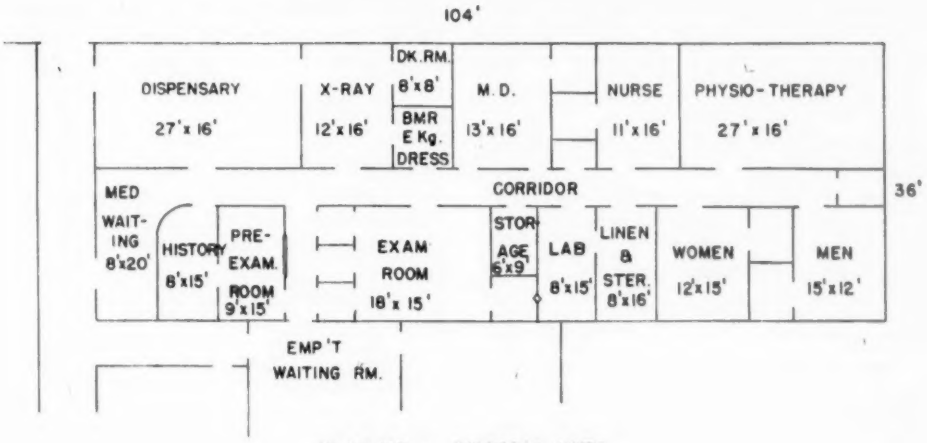
In *Plan No. 2,* the office is the real workshop and occupies a central position in the health unit. It has a desk, chair, file cabinet, bookcase, one additional straight-back chair and one comfortable "visitors" chair. This room should be attractively furnished with shaded lights and comfortable furniture to help put workers at ease. (See diagram, Plan No. 2.)

When it is feasible an exit from the private office to the street or to an outside corridor is useful so that a worker who has been injured or who is emotionally upset can leave without embarrassment to himself or distraction to others.

The dressing room is long enough to permit making the standard vision test, again with the aid of a mirror to provide the required 20 feet. A rest room of dormitory proportions is included because some plants require augmented facilities for temporary rest periods. The rest rooms meet the standards set by the Minnesota Department of Health for floor area and bed spacing in hospitals and related institutions.



PLAN NO. 2 FIRST-AID & REST ROOM



PLAN NO. 3 MEDICAL UNIT

Plan No. 3 is an example of planning a preallocated space for maximum use of existing facilities. It permits common use of the registration desk by both applicants for work and employed personnel and keeps the two groups separate by means of routing of work. (See diagram, Plan No. 3.)

Employees requesting care enter the medical waiting room directly from the corridor connected with the plant. They stop at the registration desk and are directed to the dispensary or the doctor's office as indicated. There is an exit from the dispensary to the outside corridor, facilitating prompt return to work and reducing cross-traffic to a minimum.

Applicants for employment remain in the waiting room of the employment department until called. Registration and necessary information are recorded by the same personnel registering regularly employed workers. Here the nurse takes and records the preliminary health history, pulse, temperature, respiration, blood pressure, vision, and hearing. The prospective employee is then directed to one of the dressing rooms which opens into the examining room. Here the complete physical examination is given, with the exception of photo-fluoroscopic screening and x-ray, the electrocardiogram, and the basal metabolism rate. A specimen of urine is left on the revolving shelf between the toilet and laboratory, and the applicant is directed to return to the dressing room and dress, except for his undershirt and shirt. He puts on his suit coat (or top coat), and carries his remaining clothing with him to x-ray, where the examination is completed. He may use the adjoining electrocardiogram room in which to wait until the film is developed and it is determined whether the x-ray is satisfactory, after which he returns to the employment waiting room.

The three examination booths permit one applicant to undress and another to dress while the third is being examined. If the patients are directed to x-ray promptly, the dressing rooms can be used to maximum capacity and there will be no waiting periods for the examining physicians between patients.

The doctor's and nurse's offices are situated centrally because it is desirable for professional personnel to be immediately available in the several areas of the medical unit. Adequate storage for drugs and supplies is provided through the inclusion of a storage room and drug closet.

THE TEST of satisfactory physical facilities for a plant health service is fitness to purpose. With certain exceptions such as when the community has no other hospital, an industrial health service is designed for the use of ambulatory patients. It is planned to accommodate a known

group as to numbers and sex, and this group within the normal range of seasonal and occupational fluctuation is relatively stable. It is set up to meet the need of known emergencies, based on evaluated experiences of various types of occupations.

The availability of "tools" and materials is as necessary to medical professional workers as to expert workers in any other department, and the routine of work should be based on the same principles that underlie the scientific routing of material and work in any other department.

The adequate, compact, well equipped, uncluttered unit of rooms, with advantageously placed entrances and exits, will facilitate effective service, and the right arrangement will conserve the time of both professional personnel and the workers.

REFERENCES

American Medical Association, Council on Industrial Health. "Medical Service in Industry: The Industrial Medical Department." *Journal of the American Medical Association*, July 5, 1941, p. 34.

Gafafer, W. M. (Editor). Manual of Industrial Hygiene and Medical Service in War Industries. W. B. Saunders Company, Philadelphia, 1943.

Gissane, William, Miles, A. A., and Williams, R.F.O. "Design of Dressing Stations and Control of Wound Infection." *British Journal of Industrial Medicine*, April 1944, p. 90.

Ritter, W. L., and Dugger, J. W. "Industrial Health Units, Considerations and Designs for the Smaller Installations." *Industrial Medicine*, October 1943, p. 650.

FEDERAL APPROPRIATIONS FOR 1946

The April and May issues of the Bulletin of the Child Welfare Information Service, Inc., 930 F Street, N.W., Washington 4, D.C., give the following information about appropriations for federal government programs in 1946:

Funds for the next fiscal year for several federal health and welfare agencies including the Children's Bureau, USPHS, Office of Vocational Rehabilitation and others are included in bill HR 3199, the "Labor-Federal Security Appropriation Bill, 1946," now pending. The House has already approved certain appropriations which are now under consideration by the Senate. The House approved amounts for the regular activities of the Children's Bureau and the Office of Education similar to last year. The appropriation for child labor law enforcement was not increased although the number of employed children between 14 and 17 years increased from 1 million in 1940 to 3 million in 1945 and CB asked for additional funds. No funds were approved by the House for the Office of Community War Services or for the Committee on Physical Fitness after June 30, 1945. The approved appropriation for the Office of Vocational Rehabilitation was increased over last year by $258,000. The states estimate they will handle 352,000 cases in 1946 as compared with 290,000 in 1945. To the Public Health Service $12,000,000 was allotted for venereal disease control, over $6,000,000 for tuberculosis. The amount for communicable disease control was increased over last year. An appropriation of $59,957,000 was approved to continue the training program for nurses. The appropriation does not specifically provide for giving postgraduate courses of study but the House Appropriations Committee expressed its feeling " . . . that every effort should be made to continue the postgraduate program within the funds here recommended." An appropriation of $317,000 was approved to enable the Public Health Service, either independently or in cooperation with public and private agencies, including individuals, to plan postwar health and health facilities construction programs. This fund will enable the development of plans for hospitals, health centers, and other public health facilities. The USPHS has had no regular appropriation for this activity although it has carried on such work to a limited extent.

The Department of Agriculture now has funds to continue until June 30, 1946 the federal school lunch program on the same basis as at present. Bills are before Congress to give legislative authority to the school lunch program by providing federal aid on a permanent and expanded basis.

The Federal Works Agency has funds to continue its day care program for children of working parents until June 30, 1945, but cannot make commitments after that date unless Congress actually appropriates funds for next year. An amendment to the "Lanham Act" is pending under which funds would be authorized for the period after June 30, 1945.

The Volunteer Office and the Public Health Nursing Agency

By EVELYN K. DAVIS

VOLUNTEER SERVICE was never so important to public health nursing as it is now in a world at war. Visiting nursing associations have long recognized the importance of the volunteer but it is important today to review our beliefs and strengthen our programs.

Several reasons could be listed for the use of volunteers. The three which stand out today are probably the following:

First, every visiting nurse association, health department and school health service is short of staff. How can these agencies carry on in the face of increased need and fewer workers? Through the use of volunteers agencies have found it possible to get their work done. Look at what is happening in the civilian hospitals where hundreds of volunteers are helping to meet the daily need.

Second, today we find an increased interest among people to want to help. They want to do their share in winning the war and to keep the home front strong and ready to meet the problems in the postwar period. It is most important for community agencies to use this energy and desire now and to plan for the continued use of the many volunteers who have been contributing to the war programs after the war is over.

Third, more people need to know about the services public health nurses are rendering in order to make greater and better use of them. The volunteer worker who assists the nurse in the program itself can be one of the best personal interpreters of the program. There is an old Chinese proverb which says, "If you hear about a thing, you soon forget it; if you see it done, you remember half of it; if you do it yourself, you remember all of it." The volunteer doing a job with the public health nurse will always remember that agency.

In the years since Pearl Harbor there has been developed throughout the country a community machinery to assist the volunteer to find his place in the war effort and assist the agency to find and to use adequately the volunteer manpower. This community machinery is called the Civilian Defense Volunteer Office, the Volunteer Service Bureau, or just the Volunteer Office. This type of organization is not a new plan developed in the war because before 1941 there were some 50 volunteer offices organized by councils of social agencies in their communities. With the organization of the Office of Civilian Defense this idea was enlarged and promoted. In almost all defense councils or civilian defense organizations some machinery was set up for the registration and referral of volunteer workers. Volunteer offices which existed before the war were turned over or loaned to defense councils and in many communities excellent volunteer offices were organized. Thousands of volunteers were enrolled, trained and referred to community services.

Today councils of social agencies and defense councils are developing plans so that when the war is over the transition to peacetime volunteer programs will be easy. It is most important that the gains made during this period are not lost and that the volunteer will bring his new experience to the community program. Community planning for volunteer service has proved its worth and will take its

Miss Davis is director, Volunteer Service Bureau, Greater Boston Community Council; was formerly on the NOPHN staff.

place in our council development as one of the essential services in the postwar program.

A volunteer office cannot do the job alone. Its success depends primarily on the close cooperation each agency gives it. I am not going to describe a volunteer office—its function, program, its other characteristics, as this has been done before. What I want to discuss is how I think the public health nursing agency should cooperate with the volunteer office for their mutual benefit.

The first job is to study, analyze and organize the volunteer program within your own agency. In working with agencies in the community we find that it is important for one person to be in charge of the volunteer program in each agency. In several hospitals using hundreds of workers there is a full-time paid director of volunteers, in some only a part-time paid worker; in others it will be a full-time or part-time volunteer. The essential thing is that one person have the responsibility. Of course the volunteers will work under different people and in different jobs but unless there is a chairman or one person responsible the volunteer often becomes lost and rarely sees the total picture.

The next task is to analyze carefully the jobs to be done and outline the duties in detail. When you refer a job to the volunteer office you will be required to tell them the hours of work, the days of the week, detailed description of duties, and qualifications you would like to have in the volunteer. When the interviewer in the volunteer office is trying to recruit for the job, the first thing she is asked is, "What will I have to do?" Too frequently we find the volunteer will be asked to do a lot of other things after he has started the job and often this discourages him and he drops out. Not that volunteers cannot be advanced to other jobs when they have learned the work and qualify but that should come later and not at first.

The volunteer should be carefully interviewed when he comes to your agency and a picture given him of the agency's program. He should be made to feel at home, given a place to leave his things, introduced to the staff, and assigned to his job. If it is needed, training for the job should be given. Some agencies have a short training course, some have instruction sheets, a manual, or individual training by another volunteer. Group meetings of volunteers, attendance at staff meetings, will all help to equip the volunteer for his work and develop his interest in the program as a whole.

A record of the work of the volunteer is also important. It helps to develop the volunteer; it will be a record of performance so that it can be reported to the volunteer office. Some agencies have the volunteer sign in and sign out each day they serve; some keep a record card both of hours of service and work accomplished.

If the volunteer is capable an opportunity should be given for promotion. Recognition of work well done is sometimes the only satisfaction a volunteer receives. The agency which takes the opportunity to give recognition in the annual report, in the annual meeting, or by a "Volunteer Day," or a letter of thanks when a volunteer has completed a task, will find the returns more than justify the work entailed.

The volunteer office finds that the agency which carries out the above program will hold its volunteers and knows that when a volunteer is referred he will be made welcome and used effectively.

The volunteer office in a given community will probably not be able to obtain all the volunteers a visiting nursing agency will need. In fact I do not think the agency should depend only on the volunteer office. Some of the members of your board of directors should be good volunteers, friends of your volunteers may be recruited, your clients may help by serving or recruiting. The important thing in cooperating with the volunteer office is to be certain we are not duplicating effort. The volunteer office should contact the citywide organizations, the colleges, the churches. A citywide recruitment campaign should be conducted by the volunteer office because they can interview the volunteers and refer them

where they can serve best. It is important for you to refer to the volunteer office volunteer workers you cannot use or volunteers who may wish to do some other work. Too often a volunteer goes from agency to agency offering his service and is turned down—not because he is not a good volunteer, but because he just does not seem to fit into the program. Think what that means when we make an appeal for workers. The central volunteer office is the place to refer volunteers where they will be able to see the total community needs and find the place where their skills will be used to the best advantage.

Please call the volunteer office as early as possible when you need volunteers. Too frequently a call comes in for volunteers for that afternoon or tomorrow morning at nine. Most volunteer offices will try very hard to meet these emergency calls but volunteers unfortunately are not sitting around at home waiting for a call. A day or so advance notice will enable the volunteer office to render better service.

It is important also to report to the volunteer office when your job is filled or when some change is made.

Volunteer offices usually call to make the appointment for a volunteer. It is then important to report back to the volunteer office if the volunteer did not come in, or if he did, the results of the interview. Several offices are using a referral card which the volunteer brings with him to be filled out and returned to the volunteer office. This cooperation in record-keeping enables the volunteer office to follow up on volunteer service so that better referrals can be made. A volunteer who does not work out well in one job should be referred to another type of work. A volunteer who has done well is pleased to be told by the worker in the volunteer office that a good report has been received of his work. He will do the next assignment more readily and we will all receive better volunteer service.

Community planning for money raising, research, health and welfare services has long been recognized as essential. Community planning for volunteer service is to my mind just as essential. The volunteer office which is a part of the city's community organization structure and has the full support and cooperation of each agency using volunteers can do much to strengthen all volunteer service.

ADDITIONAL SUMMER COURSES

California

Los Angeles. University of California, Extension Division. August 20-31. Two short, intensive courses in the supervision of public health nursing: (1) an introductory course presenting methods, functions, principles, and organized plans for those beginning or preparing for supervision in public health nursing agencies (2) an advanced course dealing with the supervision of nursing which is open to directors, assistants, and advanced supervisors. Ruth Freeman will be the guest instructor in both courses. The courses will meet daily, Monday through Friday, for a total of 10 meetings, the latter course in the evenings. For further information, write University of California Extension Division, Eighth and Hill Streets, Los Angeles 14.

Michigan

Ann Arbor. University of Michigan. July 30-August 11. Venereal disease nursing. August 13-August 25. Tuberculosis nursing. July 2-August 11. Introduction to physiologic hygiene, introduction to maternal and child health, introduction to mental hygiene, materials for school health education, field problems in tuberculosis control, race hygiene. July 2-August 24. Introduction to physiologic hygiene, introduction to public health law and administration, introduction to public health administration problems, introduction to public health economics, introduction to public health nutrition, introduction to public health statistics, problems in public health statistics, bacteriology of dental caries. July 2-September 1. Field work in non-official public health nursing. September 3-October 20. Field work in urban official public health nursing, field work in rural health nursing. One week non-credit in-service training courses: July 9-July 13—school nursing, August 27-August 31—general public health nursing, industrial nursing. Write to the Office of the Dean of Women, Barbour Gymnasium, for summer term catalogues for other courses and for additional information.

Review of a Polio Epidemic

By MARION WILLIAMSON, R.N.

FIGURES from the State Department of Health, Division of Epidemiology, show that in 1944 Kentucky had the most severe poliomyelitis epidemic recorded in the history of the state. From January 1 to November 1, 1944, 718 cases were reported, 249 in Louisville and Jefferson County, and 469 in other counties in the state. The largest number of cases previously recorded in any one year was 333 in 1935.

A few scattered cases occurred during the first few months of the calendar year; however, the actual epidemic did not begin until early in May in Muhlenberg County. In all, 37 counties were classified as epidemic areas, reporting 2 cases for each 10,000 population.

As acute cases were reported to the headquarters of the Kentucky Crippled Children Commission in Louisville, immediate hospitalization was provided if the doctor in charge of the case and the parents or guardian of the patient gave their consent. There was no question of race, creed, age, or economic status. The only requirement was that some member of the family come to the Commission office to give a social and physical history and to sign a statement giving permission for treatment.

At the beginning of the epidemic, the Commission was able to hospitalize all acutely ill patients at the Kosair Crippled Children Hospital. This was done by transferring to the first floor of the hospital patients who had had poliomyelitis in previous months, thereby releasing the isolation department for emergency cases. As the demands for admittance increased with the spread of the epidemic to other counties, it became evident that additional hospital beds would be needed. Alarmed by the numerous requests coming to her daily, the director of the Commission called a meeting on July 5, 1944. This meeting was attended by the president of the Kentucky Crippled Children Commission, the professional staff, orthopedic surgeons, the city-county health directors, the state epidemiologist, the state health commissioner, and several lay persons.

It was agreed by the doctors at this meeting that if an epidemic proper should occur the Kenny hot foments and muscle reeducation would be used, in spite of the fact that this type of treatment would require early hospitalization for the majority of cases. Dr. Hugh Leavell, director of the Louisville and Jefferson County Health Department, offered the Commission use of 20 beds in the isolation department at the General Hospital in Louisville. This offer was accepted and a physical therapist was at once transferred from the Kosair Hospital to the General Hospital isolation department, in order to give the children admitted there the best possible care.

During the early part of the summer, parents were merely requested to keep children out of crowds; but on July 8, 1944, children under 14 years were banned from Sunday schools, churches, theaters, swimming pools, and all public gatherings.

As the disease spread in Louisville and Jefferson County and still further requests came from other counties, two additional isolation wards were opened at the General Hospital.

THERE WAS now a critical need for trained nurses and physical therapists.

Miss Williamson is director of the Kentucky Crippled Children's Commission, Louisville.

A request was made to the American Red Cross for graduate nurses and to the National Foundation for Infantile Paralysis for physical therapists. The response from both organizations was most gratifying. Seven physical therapists were sent to Kentucky by the National Foundation. On July 14, 1944, the first group of graduate nurses recruited by the American Red Cross reported for duty. During the epidemic proper 141 graduate nurses were employed by the Kentucky Crippled Children Commission, with salaries and maintenance paid by the Kentucky State Chapter of the National Foundation for Infantile Paralysis.

A request was made by the state health commissioner to the medical department of the National Foundation for Infantile Paralysis that a representative come to Louisville to discuss financial assistance. After a meeting with state people on July 21, 1944, a contribution of $50,000 from funds of the National Foundation for Infantile Paralysis was made, with the understanding that an additional $50,000 would be available when needed. In addition, all wool used in the epidemic here was furnished by the Foundation; and respirators were secured from Chicago and Kansas for Kentucky's use. Other respirators were furnished by the Forty-and-Eight Club, Ashland, Kentucky, and the Illinois Central Railway Hospital, Paducah, Kentucky, as the increase in respiratory cases created a demand.

By August 1944 the Commission had filled all beds in the poliomyelitis department at the Kosair Hospital and had admitted over one hundred cases to the three wards at the General Hospital. As an emergency measure, it was then decided to transfer from the Kosair Hospital all children suffering from a crippling condition other than poliomyelitis. Cases which could be sent home for a period of time were discharged. The remainder were transferred to St. Joseph's Infirmary, Louisville, and the entire bed capacity at the Kosair Hospital has since been used for poliomyelitis cases.

As requests came to the American Red Cross for nursing service in other states which were affected by the epidemic and the nursing situation again become critical, an appeal was made to the state, county and city health departments for assistance from public health nurses. This request had a two-fold purpose (1) to enlarge our staffs in the hospitals and (2) to secure nurses from counties where there were a few scattered cases, so they might receive training in the Kenny method and be able to return to their counties to help parents care for the mild cases at home.

OF THE 718 cases with onset in 1944, 470 were hospitalized; the majority of the remaining 248 cases were mild ones treated in the homes. Of these 282 were under five years of age, 99 were between the ages of five and fifteen years, 325 were fifteen years or over, and there were 12 whose ages were unknown. Of the 470 cases hospitalized, 253 patients have been discharged. Upon discharge from the hospital, written instructions are given the parents of each patient regarding home care. These instructions are given by the orthopedic surgeons, nurses, and the physical therapists. Discharged patients are followed up through visits to doctors' offices, out-patient clinics, and itinerant clinics. It is believed that a number of the 1944 unreported poliomyelitis cases will also eventually appear at these clinics.

A progressive and far-reaching program for patients who have had poliomyelitis is the establishment of a new physical therapy out-patient clinic at the General Hospital. This clinic will be under the joint supervision of the Kentucky Crippled Children Commission and the University of Louisville School of Medicine. The personnel of this clinic will be an orthopedic doctor, an orthopedic public health nurse or social worker, two physical therapists, and a secretary. While the clinic proper will be in the General Hospital (and we believe this is a wise decision because of medical supervision), the patients will use a separate entrance, opening from the court, and the clinic will be available to children from all counties in the state. As many of the children will require long con-

valescent care, the establishment of the clinic will make possible earlier discharge, thereby releasing hospital beds for additional cases.

ONE ASPECT of poliomyelitis which seems worthy of special mention here are the psychological factors in connection with hospitalization of patients, such as (1) emotional disturbance of parents because of the child's condition and the family's economic status (2) fear of the disease itself, fear for the child afflicted and fear of the disease's spread to other children in the family and (3) neighborhood antagonisms resulting in isolation of the family. As parents have come in to the office to give necessary histories, our social worker, or another member of the staff, has interviewed them. The following incidents indicate typical reactions:

In an attempt to keep children isolated, a number of parents described the crippling effect of poliomyelitis, creating a state of fear and anxiety which resulted in undesirable mental conditions if the children became ill.

In some instances the entire family was isolated by the neighbors when one member of the family became ill. This caused resentment as well as fear. On several occasions, the neighbors were so frightened they would not raise their windows on the side next to the home of the stricken patient. People living in the same block would walk on the other side of the street to avoid passing the patient's house, even though the patient had been taken to the hospital.

Fathers who had gone to and from work in a car pool were refused transportation. One father, living in Bullitt County and commuting to Louisville each day, lost five weeks of work because he could find no means of transportation.

Members of a family accompanying a patient to Louisville often found it difficult to secure rooms even for one night. Rooming houses and many of the hotels refused to rent rooms when it was found that the persons desiring reservations had been exposed to poliomyelitis. One wife, who brought her husband to Louisville from Daviess County for treatment, rented a hotel room. When she returned to the hotel from the hospital about 11:30 p.m., the clerk told her that he had learned her husband had polio and she could not have the room. Unable to locate another room at that hour, she returned to the General Hospital lobby, sitting there the rest of the night. She tried the next morning to find a room, but again she was unsuccessful. By the time she reached the Commission office, she was hysterical. Arrangements were made for her sister to come to Louisville to be with her and a room was found for both.

Parents of two children returning to the Commission office for instructions regarding aftercare, admitted a feeling of shame that the children had had poliomyelitis. Even though the children had only slight limps and were too large to be carried, the mothers carried them for fear people would notice they had had polio.

IN PLANNING for the future, serious consideration should be given the question of responsibility for care that is to be given poliomyelitis cases. If the doctors recommend continued use of hot foments and muscle reeducation, this will entail hospitalization of patients from the onset of disease whenever treatment cannot be carried out satisfactorily in the home.

If hospitalization will be required for the majority of cases, then definite plans should be formulated. Certainly we cannot continue to tie up all beds at the Kosair Hospital with poliomyelitis cases, when both statewide agencies, the Kentucky Society for Crippled Children and the Kentucky Crippled Children Commission, are organized for the care of children suffering from every type of crippling deformity. If the care of these cases is our responsibility and obligation, consideration should be given to the method by which this care may be given. Treatment of poliomyelitis by the Kenny method is expensive. In the acute stage, graduate nurses are required, as well as physical therapists. In the convalescent stage, physical therapists are still needed, although we have found that at this period lay women trained by the hospital staff may be used to continue application of hot foments. Fifty-five lay women have been employed in the current epidemic to apply hot packs, and this plan has worked out very well. Whenever possible, mothers of stricken patients were employed in order to train these mothers in the care of the children so that ade-

quate care could be provided by the mothers after the children were discharged from the hospital. Of course, lay persons cannot be employed until the acutely-ill stage is past.

A poliomyelitis epidemic is very much like any other emergency. During the period when anxiety and fear are aroused, it is possible to secure all assistance needed; but after the acute period of relatively short duration is over there is a convalescent period which may extend over a period of many months. What is to be done about hospital beds for these cases? Is the treatment of such patients to curtail treatment of other crippled children? How is the additional expense of such cases to be met? These are a few of the questions which should be discussed in future planning.

TEAMWORK has been the chief factor which has enabled us to meet this emergency, as strikingly indicated by the large number of agencies and individuals who gave needed assistance. Most of them have already been mentioned. The bright, smiling faces above straight, active, undeformed bodies are ample reward for all who have aided in serving Kentucky's poliomyelitis patients of 1944.

One-Day Institute

(Continued from page 293)

dent and a member of the staff as resource persons. This group recommended a training course for members who planned to assist in the office and stressed the importance of evaluating contributions of each volunteer so that they may be promoted to greater responsibilities as their knowledge and experience increased.

New for this year's program was the appointment of the Placement Committee. The chairman of this committee places volunteers in the well baby conference and arranges special activities for experienced volunteers. The vice-chairman of the Junior Volunteer Service Committee is directly responsible for placing volunteers in the office. The most stimulating feature of the evening program was the first report from this committee and the announcement of assignments for the new volunteers.

One of the outstanding recommendations of the institute was that office training course should be given. The older members felt that this course would help the volunteer learn more about the organization. The professional adviser to the group and a volunteer with a great deal of experience are outlining a course for the spring.

The success of this institute was undoubtedly founded on the fact that the Junior Volunteer Service Committee of the Visiting Nurse Association is well set up as a volunteer organization. It has its own by-laws and elects its own officers. The chairman is an appointed member of the Visiting Nurse Association Board of Directors and is represented on the Visiting Nurse Association Publicity Committee. The professional adviser is the assistant director of the Visiting Nurse Association and the lay adviser a member of the Board of Directors. This one-day institute will prove a great benefit to the volunteer and to the Association in which she serves.

There was a unanimous decision that the mid-winter institute should be an annual event.

ELEANOR F. JERMYN, VICE-CHAIRMAN
JUNIOR VOLUNTEER SERVICE COMMITTEE,
VISITING NURSE ASSOCIATION OF SCRANTON
AND LACKAWANNA COUNTY

SCHOOLS APPROVED FOR TRAINING PHYSICAL THERAPY TECHNICIANS

By the Council on Medical Education and Hospitals of the American Medical Association

Name and Location of School	Entrance Requirements*	Emergency Course: Length in Months	Emergency Course: Classes Start	Emergency Course: Tuition	Emergency Course: Certificate, Diploma, Degree	Regular Course: Length in Months	Regular Course: Classes Start	Regular Course: Tuition	Regular Course: Certificate Diploma, Degree
Children's Hospital, Los Angeles	a-b-c	6	Feb.Aug.	$200	Certificate	12	Feb.Aug.	$200	Diploma
College of Medical Evangelists, Los Angeles[1]	c	--	----------	----	----------	12	Jan.July	$215	Certificate or Degree
University of California Hospital, San Francisco[1]	a-b	--	----------	----	----------	12	Mar.Oct.	$150	Certificate
Stanford University, Stanford University, Calif.[1]	a-b-d[2]	7	Quarterly	$286	Certificate	10	Quarterly	$409	Certificate or Degree
Fitzsimons General Hospital, Denver	†	6	Quarterly	None	Certificate	--	----------	----	----------
Walter Reed General Hospital, Washington, D.C.	†	6	Quarterly	None	Certificate	--	----------	----	----------
Lawson General Hospital, Atlanta, Ga.	†	6	Quarterly	None	Certificate	--	----------	----	----------
Northwestern University Medical School, Chicago	a-c	--	----------	----	----------	9	July-Oct.	$200	Certificate
State University of Iowa Medical School, Iowa City	b-c	6	Mar.Sept.	None	Certificate	9	Mar.Sept.	None	Certificate
University of Kansas School of Medicine, Kansas City[1]	c[3]	--	----------	----	----------	9	Varies	$25[4]	Certificate or Degree
Bouvé-Boston School of Physical Education, Boston	c[3]	6	July	$250	Certificate	36	Sept.	$400 yr.	Degree
Harvard Medical School, Boston	a-b-c	6	Varies	$250	Certificate	9	Varies	$300	Certificate
Boston University Sargent College of Physical Education, Cambridge, Mass.	H.S.	--	----------	----	----------	36	Oct.	Varies	Degree
Percy Jones General Hospital, Battle Creek, Mich.	†	6	Jan.July	None	Certificate	--	----------	----	----------
University of Minnesota, Minneapolis[1]	a-b-c	--	----------	----	----------	12	Jan.	$200	Certificate
Mayo Clinic, Rochester, Minn.[1]	a-b-c	6	Jan.July	None	Certificate	12	Jan.July	None	Certificate
Barnes Hospital, St. Louis[1]	a-b-c	--	----------	----	----------	9	Oct.	$200	Certificate
St. Louis University School of Nursing, St. Louis[1]	a-b-c[3]	--	----------	----	----------	9	Sept.	$250 yr.	Certificate or Degree
O'Reilly General Hospital, Springfield, Mo.	†	6	Quarterly	None	Certificate	--	----------	----	----------
Columbia University, New York City[1]	a-b-c	--	----------	----	----------	10	Feb.Sept.	$480	Certificate
Hospital for Special Surgery, New York City[1]	a-b-c	--	----------	----	----------	9	Sept.	$300	Diploma
New York University School of Education, New York City[1]	a-b-c	--	----------	----	----------	9	Feb.Sept.	$450	Certificate or Degree
Duke Hospital, Durham, N. C.[1]	a-b-c	--	----------	----	----------	12	Oct.	$200	Certificate
Cleveland Clinic Foundation Hospital, Cleveland	a-b-c	--	----------	----	----------	9	Sept.	None	Certificate
D. T. Watson School of Physiotherapy, Leetsdale, Pa.[1]	a-b-c	6	Oct.	$200	Diploma	12	Oct.	$200	Diploma
Graduate Hosp. of the Univ. of Pennsylvania, Philadelphia[1]	a-b-c	--	----------	----	----------	12	Jan.Sept.	$200	Certificate
University of Texas School of Medicine, Galveston[1]	a-b-c	--	----------	----	----------	9	Jan.	$100	Certificate
Brooke General Hospital, San Antonio, Texas	†	6	Quarterly	None	Certificate	--	----------	----	----------
Bushnell General Hospital, Brigham, Utah	†	6	Jan.July	None	Certificate	--	----------	----	----------
Richmond Professional Institute, Richmond, Va.	a-b-d	--	----------	----	----------	9	Sept.	$200	Certificate or Degree
Ashford General Hospital, White Sulphur Springs, W. Va.	†	6	Feb.Aug.	None	Certificate	--	----------	----	----------
University of Wisconsin Medical School, Madison[1]	a-b-c	--	----------	----	----------	9	Sept.	Varies	Certificate

*Courses are so arranged that any of the entrance requirements will qualify students for training. a = Graduation from accredited school of nursing; b = Graduation from accredited school of physical education; c = Two years of college with science courses; d = Three years of college with science courses; H.S. = High school graduation.

†For complete information regarding entrance to Army training schools write to Major Emma E. Vogel, Director of Physical Therapists, Office of the Surgeon General, War Department, Washington 25, D. C.

1. Male students admitted.
2. High school graduates accepted for four-year course leading to A.B. degree; students admitted quarterly and tuition is $143 per quarter.
3. High school graduates admitted to four-year college course.
4. Non-residents charged additional fee.

—From Approved Schools for Physical Therapy Technicians, *The Journal of the American Medical Association*, March 31, 1945.

Supervision—A Teamwork Job

By MARY ELLA CHAYER, R.N.

AT THE 1942 Biennial Convention a committee was authorized by the School Nursing Section of the National Organization for Public Health Nursing to set up standards for supervision of school nursing. The purpose of the committee was the improvement of school health programs and it was felt that improvement would result only as local communities studied their needs and did something about them. Accordingly a plan was made to encourage the appointment of subcommittees in each of the 48 states. State directors of public health nursing were asked to submit names of outstanding school nurses and supervisors of school nursing employed by various types of agencies. From their suggestions and after a great deal of effort, 39 state committees were started with a total membership of about 180 nurses. The present series of articles would not have been possible had it not been for the continuous and interested participation of these committees.

A series of study guides were prepared and sent out from time to time during a period of two years. These guides contained suggestions for analysing local needs and included:

1. Making a state survey of nurses engaged in school nursing and the agencies providing supervision.
2. Securing opinions about the essentiality of activities commonly performed by school nurses.
3. Exploring the problems of school nurses and the sources to which the nurse turned for help with them.
4. Analysing the activities of supervisors as to their effectiveness in improving the quality of nursing service, in improving the school health program, and in strengthening the supervisors' own work.

Analysis of local problems through these study guides indicated a need for some agreement upon principles which should guide supervisors and administrators. A statement of "Principles and Standards of Supervision of School Nursing" was prepared and presented for discussion at the 1944 Biennial in Buffalo. Twenty-nine delegates from 24 states attended the meeting, attesting the widespread interest in this project. As a result of the discussion and further written suggestions from various state committee chairmen, a monograph based on these standards and principles was prepared and published in the February 1945 issue of PUBLIC HEALTH NURSING under the title, "Improving the School Health Program through Supervision of School Nursing."

The next step was to tabulate, analyse, classify and interpret the supervisory activities of 69 supervisors who answered a questionnaire. Nineteen states were represented among the 69 supervisors. The contents of this material were summarized and made the basis of two articles, one which appeared in the April PUBLIC HEALTH NURSING, and the other in May.

In summarizing the outcomes of the study we can say that there was guided activity on the part of more than 200 school nurses and at least 69 supervisors. Several supervisors have made the problems of supervision the subject of staff education programs covering a period of two years. There has been an increasing awareness on the part of supervisors participating in the study of the need to identify their supervisory problems. Many statements of problems were vague and scattered early in the study.

The 1944 census of public health nursing indicates that there are a few more

school nurses and supervisors being employed by boards of education than during previous years, notwithstanding the shortage of nurses.

The three articles in PUBLIC HEALTH NURSING, together with this report will soon be available in one monograph for wide distribution to nurses, supervisors, administrators and public health nursing instructors.

RECOMMENDATIONS

As a result of the study, the committee wishes to submit the following recommendations, some of which were suggested and acted upon at the 1944 Biennial:

1. That the state committees which have cooperated in this study continue to function under state auspices, their purpose being to study the problems of school nurses and to offer assistance to local agencies in providing supervision.

2. That these committees foster close relationships with such agencies as state departments of education, state health departments, and state organizations for public health nursing.

3. That the state committees work through and with the above agencies—

a. In planning and conducting an annual census of nurses doing school nursing and of supervisors of school nurses—generalized or specialized—and their employing agents.

b. In keeping a roster of superintendents of schools to whom literature may be sent.

4. That the committee keep a roster of all communities not providing local supervision to school nurses and study ways in which these communities may solve their problem; and that every effort be made to distribute supervisors to an increasing number of communities.

5. That committees work toward a high quality of school nursing performance through careful selection and preparation of supervisors of school health work.

6. That committees work toward joint participation by state departments of health and state departments of education in setting up adequate standards of preparation and certification of school nurses and of school nurse supervisors.

This is the final report of the Committee to Set Up Standards of Supervision for School Nursing. This group is composed of a Central Committee—Mary Ella Chayer, chairman; Lula P. Dilworth; Marie Swanson; Bosse B. Randle—and 39 state committees with the following chairmen:

Arizona—Mrs. Jennette Banker, Phoenix; Arkansas—Mary Ella Clayton, Fort Smith; Colorado—Mrs. Gretchen Blanpied, Denver; Connecticut—Marion Redmond, New Haven; Delaware—Mary Jones, Georgetown; District of Columbia—Mildred Negus; Florida—Mrs. Inez Nelson, Jacksonville; Georgia—Helen E. Bond, Savannah; Idaho—Dorothy Collard, Twin Falls; Indiana—E. Nancy Scramlin, Muncie; Iowa—Nan Clack, Mason City; Kansas—Belle Jeannette Rosenstock, Topeka; Kentucky—Mrs. Carabelle K. Hunt, Louisville; Louisiana—Christine Causey, New Orleans; Maine—Geraldine Hiller, Portland; Maryland—Letha Allen, Baltimore; Massachusetts—Ethel Brooks, Boston; Michigan—Evelyn Ellingson, Lansing; Minnesota—Cora Helgesen, Minneapolis; Mississippi—Lucy Massey, Jackson; Missouri—A. Mary Ross, Kansas City; Nebraska—Grace Pinckney, Omaha; Nevada—Therma Green, Las Vegas; New Hampshire—Elizabeth M. Murphy, Concord; New Jersey—Mary B. Hulsizer, Newark; New Mexico—Mrs. Beatrice Crewe Martin, Albuquerque; New York—Mildred Meek, Niagara Falls; North Carolina—Mrs. Glenn C. Cline, Concord; North Dakota—Anne MacNeill, Fargo; Ohio—Ethel Osborne, Cleveland; Oklahoma—Josephine L. Daniel, Oklahoma City; Pennsylvania—Mrs. Sara S. Stanton, West Reading; South Carolina—Mrs. Minnie H. Blease, Saluda; Tennessee—Mrs. Thelma Rion Bush, Nashville; Texas—Mrs. Beryl Michael Phares, Dallas; Vermont—Esther Martinson, Barre; Virginia—C. Viola Hahn, Richmond; West Virginia—Mrs. Grayce S. Hoke, Charleston; Wyoming—Eileen Goodall, Laramie.

A County Home Delivery Nursing Service

By SIDNEY J. WILLIAMS, M.D.

PIKE COUNTY is in southwest Mississippi and borders on Louisiana. With an estimated population of 35,900, of which 55 percent is white, this county depends for its financial support largely upon agriculture, dairying, and various industries, among which the Illinois Central Railroad shops and lumber mills are primary. The county's assessed property valuation is approximately $10,300,000.

The Pike County Health Department now functioning began operation on July 1, 1931. The Commonwealth Fund agreed to participate in the program for a period of five years provided the State Board of Health and the local county and city appropriating bodies would gradually assume the full financial responsibility of the department. This they did on January 1, 1938.

The size of the staff has increased with demands on the department for service. Until the home delivery nursing service was instituted, the staff consisted of the health officer, one sanitation supervisor, one supervising nurse, four district nurses, one dental hygienist, one statistician, and one secretary. This special maternity program necessitated the employment of two more district nurses, and the county was redivided to form six nursing districts. An additional clerk and special venereal disease investigator were added in 1942, and an assistant supervising nurse in 1943. Medical service at venereal disease clinics and maternal and child health conferences is supplied by local physicians working on a part-time basis. A part-time nurse is used in some of these clinics.

When first organized, the department's program for maternity service consisted entirely of antepartum and postpartum nursing service. Nursing service to antepartum patients consisted of checking blood pressure and temperature, collection of urine specimens for examination, educational work with regard to diet, exercise, rest, elimination, clothing, and the need of adequate medical care. The necessary preparation for delivery was discussed, and symptoms of possible complications were outlined. Medical conferences were later organized and in 1933 the collection of blood for diagnosis of syphilis was added to the nursing service and arrangements were made to secure treatments for those found to be positive.

Because of the unenviable maternal, neonatal and infant death rates and the stillbirth rate which prevailed, a survey of maternity care facilities of the county was made. The high percentage of preventable deaths revealed suggested the desirability of developing a delivery service in the county as an aid to physicians in the care of patients in the home. Such a service was inaugurated in 1938 and has cared for an average of about 296 patients per year.

Thus the maternal and child health program of the county now consists of antepartum, intrapartum, and postpartum nursing service, medical service at specified conferences for midwife and referred cases, and like medical service for infants and preschool children and nursing service to the latter groups.

THE HOME delivery nursing service is available without cost to all patients using a physician for home delivery, for

Dr. Williams is director of the Pike County Health Department, McComb, Mississippi. He describes a delivery service that is made part of a generalized county public health program and is not "just another delivery service" attached as a specialized service.

whom the physician desires the service. It works like this: as early in pregnancy as the physician sees the patient, he registers her with the department for nursing service. The district nurse then visits the patient and renders nursing service according to recognized standard procedures. The detailed directions for locating the patient's home as well as other pertinent findings are recorded in a special book, the "call book," for use by the nurse called for that delivery. Findings of the patient's condition at this first and subsequent visits are furnished to the physician on a form provided for this purpose, the patient being visited at least monthly and more frequently if indicated. Many patients are registered by physicians for antepartum and postpartum nursing service, where hospital delivery is planned.

Two nurses are on call at all times to go on home deliveries. All district nurses participate in rotation. A nurse goes on second call at 5 p.m. one day and on first call 5 p.m. next day. The nurse coming off first call is then off duty the succeeding day except that the nurse coming off duty 5 p.m. on Thursday is off duty until the following Monday morning. This means that each nurse has this so-called "long week-end" every sixth week. These off duty periods have been established in an effort to compensate for overtime work necessitated by this service.

When the physician is called for delivery, he in turn calls the nurse on duty. During office hours these calls come directly to the health department. At other times, the physician calls the local fire department which is just to the rear of the health department, identifies himself, and asks for a nurse. The name and telephone number of the nurse on first call is given the physician. Upon receiving the call, the nurse goes by the fire department and covers her name with the information as to where she has gone. In the event another call comes in while this nurse is out, this same procedure is repeated for and by the second call nurse. The health department does not furnish a third nurse, and only in a few rare instances has such a request come in.

The nurse goes to the home designated by the physician; in most instances the nurse and physician travel together. The health department provides, and the nurse carries with her, adequate clean and sterile supplies for delivery. Two portable delivery tables are available and are used in approximately one half of the cases.

At the time of delivery the nurse assumes the role of "floater" rather than scrub nurse, prepares the patient for delivery, sets up supplies, and assists the physician with the patient and the baby in whatever manner she can and as he directs. After the delivery is completed and the baby has received its initial care, the birth certificate and the department's detailed labor and delivery records are completed. When the supplies have been collected, the refuse is properly disposed of, and the physician is satisfied with the condition of the mother and baby, he and the nurse leave together. The nurse does not remain with the patient during labor unless the physician is also present.

Upon her return to the office the delivery is reported to the supervising nurse whose responsibility it is to see that the patient receives a visit within 24 hours, preferably by the nurse in whose district the delivery occurred. At the time of this visit, the infant is admitted to nursing service and the condition of the mother and infant is reported to the physician in charge of the case. Routine procedure calls for subsequent visits on the fifth and tenth days and more frequently if indicated. The final postpartum visit is made at the end of six weeks at which time the maternity record is closed if the mother's condition is satisfactory. The baby is followed by routine nursing and medical procedures.

SINCE this delivery service is not operated as a specialized service but has been incorporated into the general program, some adjustments were necessary in the routine operation of the nursing program as a whole. A nurse being on call two days and off duty one day means, of course, that on the average she spends two and a half to three days a week in

her district for home visiting and other procedures. However, by having six district nurses, about the same number of hours of home visiting are afforded as when there were four nurses and no delivery service.

The service has been used about 25 times a month since its beginning. It can be seen therefore that there is a considerable portion of time which the nurses on call can devote to other duties. It has developed that these nurses can perform a number of duties during regular health department working hours, and at the same time be available for delivery calls. The general plan of operation provides that the first call nurse await call at the central office where she can perform office nursing procedures such as immunizations, maternity, and other nursing visits as patients present themselves.

The keeping and sterilizing of supplies and packing bags is routinely the responsibility of a lay person employed and trained to perform such duties. The first call nurse, however, is often called on to assist this person, especially when there have been a series of deliveries in rapid succession as is frequently the case. Unless the first call nurse is out on delivery, the second call nurse assists in the regularly scheduled medical conferences and clinics at outlying points as well as those in the central office and in the regularly scheduled nursing or immunization conferences at outlying points. When there are no such clinics or conferences being held and the second call nurse is otherwise free, she quite frequently is the one who makes the 24-hour postpartum visit to a district whose nurse is not available to make such a visit by virtue either of being on first call or being away on her day off duty.

When the second call nurse is sent to make field visits, she either comes to the office or calls in at specified intervals regarding her availability for further field visits. When the first call nurse is on delivery during regular office hours the second call nurse must then make herself available for call, in which event the assistant supervising nurse or the supervising nurse carries on with such duties as were being performed by this second call nurse as outlined above. Nurses on call are not permitted to visit patients with acute communicable diseases.

THERE HAVE been 4,929 deliveries in Pike County since the delivery service was inaugurated. Of the 1,948 delivered in homes by physicians, the delivery service was used in 1,626 or 83 percent of cases. Hospital deliveries accounted for 1,377 and midwives delivered the remaining number. The year before this program was started 43 percent of the births were delivered by midwives. By 1942 there had been a 13 percent decrease in such deliveries. In 1943, 28 percent of the deliveries were by midwives.

In Pike County during the past 13 years there have been each year 64 puerperal deaths, still-births and deaths of infants in the first month of life. Information is available for only three years prior to 1931, when the average number of deaths was 82 per year. The rate per 1,000 live births for 1928-30, the period just preceding the organization of the health department, was 104.5; for the five years preceding the home delivery nursing service, 83.6; and for the past five years, 76.2. This represents a total drop in the maternal and infant mortality rate of 28 percent during the observation.

The following table compares the experience of 1,626 mothers having the delivery service with 3,303 not having this service, from July 1, 1938 to December 31, 1943. Those without the service, it will be noted, had death rates more than twice as high as those with the service.

	Home delivery service	No delivery service
Deliveries	1,626	3,303
Live births	1,590	3,164
Stillbirths	36	139
Neonatal deaths	34	149
Puerperal deaths	3	16
All deaths	73	304
Deaths per 1,000 births:		
Stillbirths	22.1	42.1
Neonatal	20.9	44.1
Puerperal	1.8	4.8
All deaths	44.9	92.0

To emphasize the fact that the delivery service is only one part of the health department's program and that it is operated without detriment to other features of the program, certain of these features deserve mention.

The health department's program also includes antepartum and postpartum nursing services to any case. With 1,002 deliveries occurring in the county last year, antepartum nursing service was rendered to 738 individuals and postpartum nursing service to 782. Of the total home deliveries, that is, deliveries by physicians with and without the delivery service and by midwives, 95 percent had postpartum nursing service; 68 percent were visited within 48 hours; and 60 percent had at least 2 postpartum visits within 10 days.

The infant service as would be expected is very closely related to the postpartum service rendered by the department. The department has two portable incubators which may be used either in homes or hospitals for premature infants, and in addition includes in its delivery service equipment so-called "premature jackets" made of cotton padded flannelette material which provide immediate protection to these infants.

Of the children born in 1942, some 72 percent were under nursing service before the first birthday. Of the infants under health department supervision in 1943, fully 92 percent were registered within one month of report.

The 1943 evaluation reveals that 95 percent of the population under five have received a standard immunizing dose of alum-precipitated diphtheria toxoid, and the communicable disease program includes immunizations against whooping cough as well as against smallpox and typhoid fever. An active tuberculosis case-finding program is being carried on in the department as well as regular home visits to unhospitalized cases and to contacts. Last year there were 94 nursing visits for each tuberculosis death.

Of epidemiologically significant cases of syphilis under treatment for one year, 80 percent had adequate treatment, according to the 1943 evaluation. Now the majority of such cases are sent to the rapid treatment centers with a systematic follow up upon discharge.

Preschool and school services are included in the nursing as well as medical program. The 1943 evaluation showed 99 percent of school children served with sanitary water supplies and 99 percent with sanitary toilet facilities. Hot lunches are available to 87 percent. These figures include both white and Negro schools.

THE COST of this delivery service is somewhat difficult to determine. The obstetric budget provides $5,660 for the service. If this provided for purely a specialized delivery service program within the department, then the cost would approach $20 per delivery. A time study conducted by this department under the guidance of the Commonwealth Fund in 1940 showed that actually 8.7 percent of the time of the nurses was spent on deliveries. It is estimated that the cost per delivery is approximately $6.50.

At the beginning the program was financed by the Commonwealth Fund as a demonstration. When this demonstration period was ended the physicians of the county were active in securing an increase in the local appropriations in order that the service be continued. At that time one of the leading physicians of the county, one who does all his obstetrics in his hospital but registers his patients with the health department for nursing service, was the one most active in securing this additional appropriation. He made the statement that if assistance to a physician at the time of delivery were the only service rendered, then the program would not be worth the cost. However, this physician went on to state that the impetus given to health education in general and the entree in certain homes thus afforded, under such circumstances as to more or less dramatically impress the public with health department services, have resulted in broad accomplishments, many of which possibly could not otherwise have been obtained. These make the value of the program far exceed its cost. This is also the view held by those of us who have worked with the program.

I do not mean to imply that the program is without disadvantages, particularly as relates to administration. We feel, however, that the advantages and overall results far outweigh any disadvantages.

In immediate prospect is another maternity care survey similar to the one made in 1937, the results of which we await with intense interest.

This brief account points out two things: first, that a home delivery nursing service can be made a part of a generalized county public health program, and second, that a service conducted in this way, instead of being a drag on the department as concerns other features of the program, gives a definite impetus to all features of the generalized program.

Presented at the meeting of the Southern Branch of the American Public Health Association, St. Louis, Missouri, November 14, 1944.

Accidental Vaccinations

A NUMBER of vaccination scars sometimes are seen in groups in which only one of the members is vaccinated. This occurs usually in crowded untidy homes where the children sleep together, or in groups where scuffling is frequent.

One outbreak in a basket ball team where a few of the members were vaccinated was drawn to my attention. During practice the unvaccinated boys brushed against the arms of those who had primary reactions, resulting in the immunization of the whole group.

Recently Mary, aged seven, was vaccinated at a clinic held in my district. The grandmother kept her home from school for several days after the pustule had formed, even though the reaction was not severe, to prevent her from having the arm bumped. This youngster slept with her four-year-old sister. There was evidence that Mary had scratched her vaccination and a second pustule formed above the site of the original inoculation.

Five days after Mary had scratched her lesion, two papules appeared on the younger sister's wrist. In several days these became umbilicated with the usual symptoms of vaccination ensuing. At this time the four-year-old accidentally hit the lesion on her wrist.

A great uncle had been helping with her care. In comforting her at this time he put his face against her arm. The uncle, 59 years old, had been successfully vaccinated when he entered school and had not had the procedure repeated in later life. He supposed himself immune until four days after this incident, when he, too, developed a typical umbilicated lesion on his chin. The cervical and submaxillary glands were greatly enlarged along with the general malaise which is experienced following a primary vaccination.

The resulting scars on these three individuals were identical and typical in appearance.

The family had been given the usual instructions for the care of a vaccination. The home was clean and the children well cared for.

This incident has served to remind me that vaccinia virus is present in the fluid of the vaccination lesion and that the lesion should be treated with respect. It gives us an excellent basis for urging simultaneous vaccination of all members of a family or household. It could, also, be used as another talking point to encourage early vaccination, as the infant does not disturb the lesion. Another fact emphasized by this experience with "accidental vaccinations" is that continuous protection against smallpox is assured only by periodic revaccination.

FLORENCE E. WALKER, R.N.
CATTARAUGUS COUNTY DEPARTMENT OF HEALTH
OLEAN, NEW YORK

Reviews and Book Notes

FOOD POISONING

By G. M. Dack, M.D. 138 pp. The University of Chicago Press, Chicago, 1943. $2.

This book concisely and accurately summarizes the existing information regarding food poisoning. The text is far from dry reading due to the interspersion of just the right amount of historical and illustrative material.

Doctor Dack divides food poisoning into three general types: chemical poisoning in food, poisonous plants and animals, and poisoning due to microorganisms or their products. He bares many widely held superstitions. Thus, he states that the term *ptomaine poison* is "unscientific and meaningless"; *tin poisoning* is practically unknown; he dubs as a myth the common concept that canned food must be removed from the container immediately upon opening lest it spoil. A splendid questionnaire form for use in the investigation of outbreaks of food poisoning is included.

This book should be on the *must* list of public health personnel—physicians, nurses, nutritionists and educators.

WILLIAM J. DARBY, M.D.
Nashville, Tenn.

FOOD ENOUGH

By John D. Black. 269 pp. Jaques Cattell Press, Lancaster, Pa., Volume I—Science for War and Peace Series, 1943. $2.50.

A professor of agricultural economics, in close touch with the War Food Administration and other wartime governmental agencies, tries "to help our people understand the complex food situation as it has developed in this war." He explains the many demands made upon the nation's food supply, and some of the shifting factors which affect the production of that supply and its distribution among our Armed Forces, allied and friendly nations, and our own civilian population. He discusses government policies and programs for determining how much and what kinds of food are needed for shifting production to obtain greater total food value and for rationing and price control. He sometimes criticizes the methods used to attain goals in themselves desirable.

For consumers, the chapters on domestic food distribution, food relief and rehabilitation, freedom from hunger (Hot Springs Food Conference), and food as a world commodity after the war, will prove especially interesting and timely. They look toward the future and many of the goals for which this war is fought.

MIRIAM BIRDSEYE
Washington, D. C.

SIMPLIFIED DIABETIC MANAGEMENT

By Joseph T. Beardwood, Jr., M.D., and Herbert T. Kelly, M.D. 172 pp. J. B. Lippincott Company, Philadelphia, fourth edition, 1944. $1.50.

This 172-page book for reading by diabetics is divided into two chapters. The authors discuss at least twenty topics in Chapter I. Some sections of the chapter are beneficial to the diabetic, but others could be detrimental. Some of the topics included are the history, principles of treatment, and the complications of diabetes. The importance of vitamins, their classification, with a chart showing the vitamin content per average serving, are discussed at length. In the section on vitamins is an illustration showing the sugar content of urine—of no value to the patient because there is no explanatory information accompanying it. The chapter concludes with discussion of the method of injecting insulin, the various types used, and general diabetic hygiene.

Chapter II is devoted to unit method charts—much too complicated for the average diabetic to understand; methods

of preparing recipes, specimen diets for diabetics with other diseases, and diets for children with diabetes. The instructions showing the use of the charts are too vague to make them clear or usable to anyone. Food tables on the percentage basis are also included in the chapter.

The authors fail to meet their objective, namely: "that basically this book is for the diabetic and should serve him as a guide." A great part of the information given and the method in which it is presented is confusing, not only to patients but also to professional people. The many complications listed might tend to make the patient worry about his condition. Sample diets would encourage him to experiment with his own prescribed diet. More general information on foods and their values, rather than on vitamins, would have been more helpful to the patient.

This book might be used advantageously as a reference for physicians or nurses, but I would not recommend it for the average diabetic patient.

AUDREY HOLT, R.N.
Kansas City, Mo.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

HEALTH EDUCATION

HEALTH EDUCATION IN RURAL SCHOOLS. By Nina B. Lamkin. *The Journal of Health and Physical Education,* October 1944, page 443. American Association for Health, Physical Education, and Recreation, 1201 Sixteenth Street, N.W., Washington, D. C. Single copy: 35c.

PLANNING FOR HEALTH EDUCATION IN THE WAR AND POSTWAR PERIODS—THE SCHOOL PROGRAM. By John W. Studebaker. *Public Health Reports,* July 14, 1944, page 904. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. Single copy: 5c.

THE USE OF RADIO IN HEALTH EDUCATION. By Harriet H. Hester. *Hygeia,* October 1944, page 756. American Medical Association, 535 N. Dearborn Street, Chicago 10, Ill. Single copy: 25c.

GENERAL

LEFT HANDED WRITING INSTRUCTION MANUAL. By Warren H. Gardner, Ph.D. 28 pp. The Interstate Printers and Publishers, 19 N. Jackson Street, Danville, Ill., revised edition, 1945. 60c.

This Manual is the result of a study made by Dr. Gardner of the writing of 25,000 school children during which he discovered that "there was nothing available in printed form which teachers could use in instructing left handed writers. As a matter of fact, the left handed child has learned to write by his own wits; from whatever he could borrow from the right hander's instruction."

PHYSICAL FITNESS FOR AMERICA. By Leonard G. Rowntree. *Hygeia,* October 1944, page 744. American Medical Association, 535 N. Dearborn Street, Chicago 10, Ill. Single copy: 25c.

REVISED BIBLIOGRAPHIES covering such topics as camping, health education texts, sex education, rural school health, and 12 others are available free from the American Association for Health, Physical Education and Recreation, 1201 Sixteenth Street, N.W., Washington 6, D.C.

FILMS

FEATURE ISSUE ON EDUCATIONAL MOTION PICTURES. *Channels,* April-May 1945. National Publicity Council for Health and Welfare Services, Inc., 130 East 22 Street, New York 10, N. Y. Single copy: 75c.

Contains excellent Bibliography on Films and Directory of Motion Pictures, as well as List of Distributors, in the health and welfare fields. Fine articles on film-making by individual agency.

INDUSTRIAL

MEN AND WOMEN LEAVING WAR INDUSTRY. By Dr. Margaret Creech. National Social Work Council, 1790 Broadway, New York 19, N. Y., 1944. 14 pp. 5 cents.

A useful analysis of wartime dislocations and

their implications for postwar planning. Summary of major problems and plans.

WORKMEN'S COMPENSATION FOR PUBLIC EMPLOYEES: AN ANALYSIS OF STATE AND FEDERAL LEGISLATION. By Leifur Magnusson. Publication No. 88, Public Administration Service, 1313 East 60 Street, Chicago 37, Illinois, 1944. 43 pp. $1.50.

EARS

SWIMMING AND THE EARS. *Hearing News*, American Society for the Hard of Hearing, 1537 35 Street, N. W., Washington, D. C., August 1937. Leaflet No. 100. 1 p.

SOCIAL HYGIENE

PROCEEDINGS OF THE PUERTO RICO REGIONAL CONFERENCE ON SOCIAL HYGIENE. Reprinted from the *Journal of Social Hygiene*, April 1944. 110 pp. Write American Social Hygiene Association, 1790 Broadway, New York 19, N.Y. 35c.

DENTAL HEALTH

DENTAL ASPECTS OF A POSTWAR PUBLIC HEALTH PLAN. By Randolph G. Bishop. *Dental Health*, August 1944, page 8. National Dental Hygiene Association, Inc., 934 Shoreham Building, Washington 5, D. C. Subscription: $1 per year.

Description of American Public Health Association postwar plan.

DENTAL PHYSICAL FITNESS. By Lt. Col. John C. Brauer, Dental Corps, A.U.S. *The Journal of Health and Physical Education*, December 1944, page 553. American Association for Health, Physical Education, and Recreation, 1201 Sixteenth Street, N.W., Washington, D. C. Single copy: 35c.

HIGH SCHOOL STUDENTS—BUILD DENTAL HEALTH NOW! Prepared by the Council on Dental Health, American Dental Association. *Hygeia*, February 1944, page 114. American Medical Association, 535 N. Dearborn Street, Chicago 10, Ill. Single copy: 25c.

CORRECTION: In the April issue, page 215, a listing of the publication, "Your Rights and Benefits: A Handy Guide for Veterans of the Armed Forces and Their Dependents," indicated that this was available for sale by the Superintendent of Documents, Washington 25, D.C. It has since come to our attention that this booklet is not for sale, but that the Superintendent does sell House Document 682, "Servicemen's Rights and Benefits," containing identical information, for 5c a single copy.

In the May issue, page 277, the names of two reviewers were unwittingly omitted. Dr. Elinor Beebe of Los Angeles, Calif., reviewed "What to Do Till the Doctor Comes"; and Mary C. Connor of NOPHN staff reviewed "A Guide to the Evaluation of Educational Experiences in the Armed Services."

THE AMERICAN JOURNAL OF NURSING FOR JUNE

A Message from the United Nations Conference . . . Katharine J. Densford, R.N.
Report From the ETO and the MTO . . . Florence A. Blanchfield, ANC
Night Shift in an Army Hospital . . . Mary Jose
The Care of Massive Injuries to the Face . . . W. G. Hamm (MC) USNR, and Alice C. Hyde (NC) USNR
Restraint in the Care of Psychiatric Patients . . . Louise Allen Meyer, R.N.
Release from Los Banos . . . Jessie Fant Evans
A Nation-Wide Counseling and Placement Service . . . Frances Oralind Triggs, Ph.D.
Physiologic Rest *Versus* Complete Bed Rest . . . William Dock, M.D.
Cutting Glove Patches . . . E. J. Stevens (MC) AUS, and Clara M. Ruehlow, R.N.
Making Nurse Education Dynamic . . . William T. Sanger
Industrial Nursing in the Basic Curriculum
A Method for Using Educational Films . . . Louise Clark, R.N.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Katherine A. Ott	Scranton, Pa.—June 5 Cleveland, Ohio—June 18-July 2
Dorothy Rusby (AWCS)	Headquarters in California—June
Ruth M. Scott	Bridgeport, Conn.—June 19
Jessie L. Stevenson	Minneapolis, Minn.—June 4-6

NOPHN field trips scheduled in May, after the May issue of the magazine went to press, included the following: Ruth Houlton attended a meeting of the Public Health Advisory Committee of the Procurement and Assignment Service of the War Manpower Commission in Washington, and Ruth M. Scott attended a meeting of the Industrial Health and Medicine Committee of that Service; Edith Wensley spoke at the annual meeting of the Visiting Nurse Association in Mt. Vernon, N. Y.; Agnes Fuller visited Chicago, Ill.; advisory service was given by Katherine Ott in Syracuse, N. Y., and Reading, Pa.; Dorothy Wiesner visited Greenwich, Conn., to observe filing practices; and Dorothy Rusby attended conferences of the SOPHN in Portland, Oreg.

ARE YOU A 100% AGENCY?

If you are a "100% agency" it signifies that every full-time nurse on your staff is a member of the National Organization for Public Health Nursing. This designation supplants the old "Honor Roll" title carried in previous years. Honor Roll Certificates are no longer issued.

The next and last 1945 listing will appear in the October magazine, so if your organization is not among the 100 percenters below, get the name of your agency into headquarters before September 5 in order that you may receive this recognition of complete staff participation in the work of your NOPHN.

ARIZONA
*Miami—Miami Public Schools
Tucson—American Red Cross, Tucson Chapter

CALIFORNIA
Los Angeles—John Hancock Life Insurance Co.

COLORADO
*Denver—Metropolitan Life Insurance Nursing Service
*Denver—Visiting Nurse Association
Trinidad—Las Animas County Health Department

CONNECTICUT
Bridgeport—Connecticut State Child Welfare Bureau, Bridgeport Branch
*Middletown—District Nurse Association of Middletown
Waterbury—Visiting Nurse Association
Willimantic—Visiting Nurse Association of the Town of Windham

FLORIDA
*Orlando—Metropolitan Life Insurance Nursing Service
*Pensacola—Escambia County Health Department

IDAHO
Rexburg—Madison County Nursing Service

ILLINOIS
Bloomington—City Health Department
Carlinville—Macoupin County Sanatorium Board
Monmouth—City Schools
Quincy—Quincy Public Health Department
Quincy—Visiting Nurse Association
Rockford—Visiting Nurse Association

INDIANA
*Evansville—Evansville Public Schools, Dept. of Health
Fort Wayne—Public Health Nursing Services of Fort Wayne and Allen County, Inc.
Kokomo—Metropolitan Life Insurance Nursing Service
*Logansport—Metropolitan Life Insurance Nursing Service
Terre Haute—Vigo County Nursing Service

IOWA
*Waterloo—Waterloo Visiting Nursing Association

KANSAS
Topeka—Metropolitan Life Insurance Nursing Service

KENTUCKY
*Columbia—Adair County Health Department
Louisville—Visiting Nurse Association of Louisville

LOUISIANA
*Shreveport—Caddo-Shreveport Health Unit

MAINE
*Dover—Foxcroft-Piscataquis County Nursing Service

MARYLAND
Cumberland—Metropolitan Life Insurance Nursing Service

MASSACHUSETTS
*Boston—John Hancock Mutual Life Insurance Company
Everett—John Hancock Mutual Life Insurance Company
*Hyannis—District Nursing Association of Barnstable, Yarmouth and Dennis
*Lowell—Visiting Nurse Association of Lowell
North Adams—John Hancock Mutual Life Insurance Company
Sandwich—Sandwich Health Association, Inc.
*Waltham—Waltham District Nursing Association

*A 100% agency for five years or more.

MICHIGAN
Ann Arbor—Ann Arbor Public Health Nursing Association
Ann Arbor—Washtenaw County Health Department
*Bay City—Public Health Nursing Service of the Civic League and City of Bay City
*Lansing—Bureau of Public Health Nursing, Michigan Department of Health
Monroe—Monroe County Health Department

MINNESOTA
Duluth—City Health Department
St. Paul—Bureau for Crippled Children, Division of Social Welfare

MISSOURI
*Jefferson City—Missouri State Board of Health, Division of Public Health Nursing
Salem—Missouri Public Health District No. 5
Webb City—Jaspar County Health Department

NEBRASKA
*Lincoln—Division of Child Welfare and Service for Crippled Children

NEW JERSEY
Atlantic City—Atlantic Visiting Nurse and Tuberculosis Association
Orange—Visiting Nurse Association of the Oranges and Maplewood
Ramsey—Northern Bergen Nursing Service
*Woodbury—Visiting Nurse Association

NEW YORK
*Batavia—Metropolitan Life Insurance Nursing Service
*Mt. Vernon—Visiting Nurse Association

NORTH CAROLINA
Asheville—Asheville City Health Department
*High Point—Metropolitan Life Insurance Nursing Service of High Point

NORTH DAKOTA
Manning—Public Health Nursing Service

OHIO
Columbus—Columbus Public Schools, Department of Health
*Toledo—Toledo District Nurse Association

OKLAHOMA
Norman—Cleveland County Health Unit

OREGON
Vale—Malheur County Public Health Association

PENNSYLVANIA
Bethlehem—Visiting Nurse Association of Bethlehem
Braddock—Public Health Nursing Association
Lansdowne—Public Health Nursing Service, Delaware County
Lycoming County—Pennsylvania State Nursing Service
*Philadelphia—Henry Phipps Institute
*Philadelphia—Visiting Nurse Society of Philadelphia, Manayunk Branch
Philadelphia—Visiting Nurse Society, North Branch
Philadelphia—Visiting Nurse Society, West Philadelphia Branch
*Pottstown—Metropolitan Life Insurance Nursing Service
*West Hazleton—The Visiting Nurse Association of Hazleton and Vicinity

RHODE ISLAND
*Providence—Department of Health and Physical Education, Dept. of Public Schools

SOUTH DAKOTA
*Sioux Falls—City and County Health Department of Sioux Falls

TENNESSEE
Chattanooga — Chattanooga-Hamilton County Health Department
*Knoxville—Metropolitan Life Insurance Nursing Service
Nashville—Metropolitan Life Insurance Nursing Service of Nashville

TEXAS
*Dallas—Dallas Public Schools—Department of School Health Work

UTAH
Salt Lake City—Utah Tuberculosis Association

WISCONSIN
*Oshkosh—Oshkosh Visiting Nurse Association
Neenah—Neenah-Menasha Visiting Nurses
Sturgeon Bay—Door County Health Dept. Nursing Service

HAWAII
Hilo—Board of Health
Honokaa—Board of Health
Honolulu—Lanakila Health Center, Board of Health
Kealakekua-Kona—Board of Health
Kohala—Board of Health
Pahala—Board of Health

NURSING FOR FARM MIGRANTS

Public health nursing service in the health program for migratory farm workers will be the subject of time and cost studies in three or four centers along the Atlantic seaboard this summer. Two supervisors and two staff nurses have conferred with NOPHN staff members regarding the possibilities and problems involved; day and posting sheets have been drawn up and are about ready for trial. Health services for migratory farm workers—some of whom are from outside the United States, Mexico and the West Indies in particular—are provided in many areas by agricultural workers health associations under federal subsidy. The total cost of the work ranges from $1.50 to $2.00 a month per person. (See "Health Services for Migrant Farm Families" by Frederick D. Mott, *American Journal of Public Health*, April 1945, p. 308.)

● Dr. Nathan Sinai, professor of public health, University of Michigan, is directing a study of the EMIC program. Hazel Herringshaw, formerly assistant professor of public health nursing at the University, is studying the public health nursing aspects. Miss Herringshaw has found the individual NOPHN Yearly Review replies of present and past years useful. The work sheets of published and unpublished studies were made available as well as minutes of committee meetings and other source material at the NOPHN.

Miss Herringshaw attended NOPHN staff meeting on May 2 and spoke of the public health nursing part of her study. She said that the EMIC program highlights and brings into sharp focus many of the problems in public health nursing.

NEWS AND VIEWS

Highlights on Wartime Nursing

ARMY NURSE GOES TO WAR

The doors of 465 Fifth Avenue, New York City, opened April 27, 1945, at 3 p.m., offering to the public a vivid display and pictorial exhibit of the activities of "The Army Nurse in War." Initiated and developed by the Army Medical Corps under the supervision of Surgeon General Kirk, with the cooperation of the American Nurses' Association and the American Red Cross, the exhibit ran through May 9, 1945, achieving a total attendance of 21,000, of whom over 3,000 were nurses. It will be shown in the principal cities of states where the available nurse census is high—the next stop being Philadelphia, as soon as arrangements can be completed.

In addition to picture blow-ups along the walls of the hall showing the history of nursing from medieval times through nursing in all the wars, the Army set up and staffed actual replicas of a field operating tent, small ward tent, nurses' quarters in the field (all complete with lifelike figure dummies realistically bandaged and painted with mercurochrome), a section of the flying ambulance, and lay-outs of surgical equipment and field medical kits. Each of these displays was in charge of an Army nurse who explained the techniques and improvisation shown. A tent theater took up a sizeable portion of the rear of the hall and sound movies, part of the Army Pictorial Service restricted film library, were shown five times daily. These covered a variety of activities in which the Army nurse plays a major part: evacuation of the wounded, medical service in Normandy and in the jungle, the field hospital, reconditioning convalescents, and the evacuation hospital. Information booths, stocked with pertinent literature, were staffed by the American Red Cross, American Nurses' Association, Army Nurse Corps, Civilian Defense Volunteer Organization, Procurement and Assignment Service, and War Information—U. S. Army.

Army bus transportation was made available to schools of nursing throughout the five boroughs of the City to facilitate the students' attendance at the exhibit. One of the metropolitan high schools gave an additional 5 points of credit to those pupils who visited the exhibit. They had cards which were stamped at the American Nurses' Association Booth for verification of their attendance, and they were required to report on the exhibit when they returned to class the following day.

The Canteen Group of the New York Chapter, American Red Cross, served coffee and doughnuts during three of the afternoons that the exhibit was open. A display on victory gardening was also set up and staffed by volunteers.

Although the original purpose of the exhibit was to be recruitment for the Corps, emphasis was changed in the direction of public relations and education, since it was felt that the general public should be made aware of the vital services rendered by the Army's Medical and Nurse Corps. Despite this change of primary purpose, the 12 days during which the exhibit was open showed an increase in the number of applications for enlistment received at the New York City Chapter, American Red Cross, and at the office of the local Procurement and Assignment Service. This is most understandable. The entire exhibit was exceptionally interesting and inspirational—detailed and well done. Don't fail to put it on your "must" list of activities should it come to your local area.

SECOND INDUCTION SERVICE

The Second National Induction Service of the U. S. Cadet Nurse Corps took place on May 12, 1945 when 60,000 cadet nurses repeated the stirring induction pledge for the first time and 52,000 reaffirmed their pledges of a year ago in ceremonies all over the country. The national program was broadcast over Mutual Broadcasting System with a roster of stars paying tribute to the cadets. Dr. Thomas Parran, Surgeon General, U. S. Public Health Service, ad-

ministered the pledge and welcomed the nurses into the Corps with the following message:

"The United States Public Health Service is proud of your splendid contribution to your country at war. You have helped release thousands of graduate nurses for military duty, while maintaining essential civilian nursing service on the home front. Because you have met your responsibilities gallantly, you are an inspiration to the whole Nation. Your country looks to you for leadership. I am confident that you will continue to lead the way in enthusiastic service until war is won on every front. As graduate nurses, you will be esteemed members of a distinguished profession, honored citizens in a great Nation."

Lucile Petry, director, Division of Nurse Education, USPHS, also paid tribute to members of the Corps, and radio and screen stars participating in the broadcast included Edgar Bergen and Charlie McCarthy, Jane Cowl, Ginny Simms, Jim Ameche and Mitchell Ayers and his orchestra.

PRACTICAL NURSE GROUP MEETS

Demand for the practical nurse to assume responsibility alongside the professional nurse was stressed at the Fourth Annual Conference of the National Association of Practical Nurse Education in New York City, May 10-11. The need for the well prepared practical nurse to assist the professional nurse has come about as a result of changes in the program of work and added responsibilities of the professional nurse but has risen to a high point at present because of the shortage of professional nurses due to demands of the military. The shortage has been particularly acute in the large hospitals, with the ratio in New York State mental hospitals as low as 1 nurse to 77 patients.

Discussion at the Conference brought out further that the practical nurse is conscious of her great opportunity in the field of nursing and anxious to share responsibility for the nursing care of patients, especially the convalescents, chronically ill and the mentally ill. The proper selection of candidates, adequate classroom instruction, the provision of field practice in line with their responsibilities and duties, and supervision and guidance by the professional nurse were pointed out as essentials in the sound development of practical nursing service. The aim is to dovetail and coordinate the work of the professional and the practical nurse so as to leave no gap in the nursing care program for the patient, whether in the hospital or the home.

The need for proper job placement was another large problem considered by the Conference. Commercial registries charge exorbitant rates and give no thought to fitting the person to the job. The emphasis of the professional registries to date has been on the placement of the professional nurse. The expressed opinion of the group was that there should be a cooperative placement service which would serve adequately both the professional and the practical nurse.

From Far and Near

● A twelve-weeks' program in tuberculosis nursing for the preparation of supervisors and consultants for public health nursing agencies and of supervisors for nursing services in hospitals is being given by Wayne University College of Nursing, Detroit, Michigan, June 18, through September 8, 1945. It is offered in cooperation with the Herman Kiefer Hospital Department of Nursing and the Detroit Department of Health Bureau of Public Health Nursing. Aim of the course is to foster understanding of the tuberculous patient and his family, medical and nursing care needed by both, the community agencies which contribute to recovery, the essentials of an adequate program of tuberculosis control, both state and local, state rehabilitation programs and opportunities for tuberculosis patients, the functions of the nurse in programs for case finding and case holding, treatment, rehabilitation and prevention.

● The Bureau of Public Health Nursing, District of Columbia Health Department, announces openings in the positions of associate public health nursing consultant, pediatrics and associate public health nursing consultant, orthopedics, with salary range for each of $3500-$4100, including $300 for overtime. Write Josephine Pitman Prescott, director, Nursing Bureau, 301 C Street, N. W., Washington, D.C.

● Seven well qualified public health nurses are needed to fill positions just established by the

legislature. Apply to Laura A. Draper, director, Bureau of Public Health Nursing, Board of Health, Honolulu, T. H.

● Metropolitan Life Insurance Company announces the following changes in territorial assignments within the Nursing Bureau of the Welfare Division:

Mabelle Hirsch has been transferred from the position of territorial supervisor in the Great Lakes and Midwestern Territories to a similar position in the Metropolitan and Atlantic Coast Territories. Mrs. Eva D. Calhoun, who has been in charge of the St. Louis County staff and southern Illinois services, succeeds Miss Hirsch. The state of Iowa has been added to the area covered by Gertrude E. Morris, territorial supervisor in the Southwestern Territory.

Grace Anderson, for several years territorial supervisor in the Atlantic Coast and Metropolitan Territories, is now local field supervisor with headquarters in Camden, New Jersey.

● Bosse B. Randle, director, Division of Public Health Nursing, Nassau County Department of Health, Mineola, New York, has joined the Children's Bureau staff on loan from her agency to participate in a study of school health services. This study precedes any effort which the Children's Bureau might make to carry out the recommendation of its Advisory Committee on Maternal and Child Health. This Committee recommended that the Children's Bureau develop a unit on school health to cooperate with the Office of Education in carrying out the recommendations of the Committee relating to the school health program. Miss Randle was part-time school nursing consultant with the NOPHN from October 1942 to January 1945 and is well acquainted with health services throughout the country.

43 Cities Apply for Retirement Benefits—Social, health and welfare workers in 43 cities have applied for enrollment in the newly formed National Health and Welfare Retirement Association, Inc., since enrollments opened April 15, Gerard Swope, chairman of the board of the Association, announced May 1. Boston, Massachusetts, is the first city whose application has been accepted. Requests for enrollment material have come from an additional 120 cities. According to Mr. Swope, five thousand applications are the minimum necessary to put the plan into active operation. It is expected that this goal will be reached by June first. Community Chests and Councils in these communities will assist the agencies to pay the employers' share in the plan for the workers.

The National Health and Welfare Retirement Association, Inc., was formed in January to extend retirement pensions and life insurance coverage to 500,000 workers in private social, health and welfare agencies throughout the country who are not now covered by federal social security. The John Hancock Mutual Life Insurance Company has agreed to guarantee the benefits offered by the Association. (See February issue of NOPHN quarterly news bulletin—*Phn.)*

New vice-presidents of this nonprofit organization include Mrs. Charles S. Brown, member of NOPHN board of directors.

Progress in Eyesight Protection—Thirtieth Annual Report of the National Society for the Prevention of Blindness shows a steady progress in the organized campaign for the protection of eyesight in America during the past three decades. Principal activities of the Society included conservation of eyesight in industry; control of glaucoma, a disease which frequently leads to blindness; and promotion of special classes and facilities for the education of children with seriously defective vision.

Outstanding development in conservation in industry, according to the report, is the Society's participation in the War Production Board's drive to speed up production through improvement of visual conditions in war industries. An advisory service on visual problems relating to production and safety offered by the Society, under a nonprofit contract with the WPB, has been used by many industries.

Facts disclosed in a study of conditions in 150 plants employing more than 400,000 workers include: only 61 percent make preplacement vision tests necessary for correct job assignment; more than 75 percent of plants making tests fail to do so under direction of an eye specialist; more than 85 percent of plants fail to recheck vision of all employees periodically; more than 80 percent make no recheck of vision of workers exposed to special hazards; 92 percent fail to recheck vision of employees with poor production records; 83 percent do not recheck vision of workers involved in accidents; and 73 percent make no rechecks where original vision test disclosed need of follow-up.

In the field of vocational rehabilitation the report suggested the application of wartime mechanical improvements for utilization of defective eyesight to the postwar program of providing useful work for visually handicapped servicemen as well as civilians hitherto unable to seek gainful employment.

1944 Activities of ASHA—In its Annual Report for 1944, the American Social Hygiene As-

sociation hails the continued advances in methods of treating syphilis and gonorrhea as a most promising development. A year of achievement, 1944 was also a year of great promise of still more far-reaching achievement in the future, Dr. Walter Clarke, executive director of the Association, declared in a statement accompanying the Report.

The Association's accomplishments for the year include: 600 prostitution surveys in the 48 states and the District of Columbia for distribution to the Army, Navy and other federal and state agencies and voluntary groups concerned with protective measures for servicemen and war industry workers; initiation of or assistance with several thousand community social hygiene programs; supplying educational materials on the venereal diseases to the Army and Navy; intensification of educational work in war industries through joint management-labor efforts; special articles on VD in more than 100 trade union newspapers and employee house organs; advice in the preparation of measures to be brought before state legislatures.

"If we are to take full advantage of present opportunities for a continued forward march against these curable and preventable diseases," Dr. Clarke said, "it is imperative that (1) federal aid to the states is not seriously reduced after the war (2) public opinion is aroused and organized to support all measures essential to the program, including especially the unremitting enforcement of laws for the repression of commercialized prostitution, and social, educational and religious activities in support of high standards of sex morals and that (3) improved diagnostic, treatment, case-finding and educational programs be provided in the civilian population in order that all infected persons may receive adequate diagnosis and treatment. Progress along these broad lines also is progress for better human relations and family welfare."

Protein Important During Pregnancy— Recent studies have indicated the importance of nutrition during pregnancy, both for the health of the mother and for that of the infant at birth and afterwards. (See "The Influence of Nutrition during Pregnancy upon the Condition of the Infant at Birth" by Burke, Beal, Kirkwood and Stuart in *Journal of Nutrition*, December 1943, "Nutrition Studies during Pregnancy" by the same authors, *American Journal of Obstetrics and Gynecology*, July 1943, and "Importance of Adequate Protein Nutrition in Pregnancy" by Philip D. Williams, *Journal of the AMA*, April 21, 1945.) Interest in the diet during pregnancy, except as it relates to the weight of the mother, has been slow to develop, but as the relationship of food to health has become recognized its importance during the earliest stages of growth has also been evidenced.

More specifically the role of protein in the diet during pregnancy is seen to be of greatest importance since (1) of all the nutritional essentials it is the most necessary for growth and development and (2) the foods which are the excellent sources of protein in the diet, such as milk, meat and eggs, furnish many of the other essential nutrients in goodly amounts. Until recently the need of an increased amount of protein for the pregnant woman has not been adequately stressed, since the obstetrician's responsibility usually ends when the woman has passed through the postpartum period and she then depends for care and feeding of her infant on a pediatrician or a well child conference.

During pregnancy, according to Dr. Williams, added to the basic needs of the body for material building and repair there are the demands of increased metabolism, the storage of nitrogen, the growth of the woman's body, the necessity for meeting needs of fetal growth and repair, the growth of the mammary tissue and the hormonal preparation for lactation. Also, the first step in ensuring an adequate supply of proper quality of breast milk must begin in pregnancy.

"Under ordinary circumstances," the Williams article states, "a desirable allowance of protein is considered to be 1 gm. for every kilogram of body weight in an adult, but nutritional authorities agree that an increase to 1.5 gm. per kilogram is safer to supply the demands of fetal and maternal growth and tissue repair in the latter half of pregnancy." This is stepped up to 2.0 gm. per kilogram during lactation.

The protein requirement for the average pregnant woman recommended by the National Research Council is 85 gm. daily; for the lactating woman, 100 gm. However, if allowances which are suggested for pregnancy and lactation are to be met in the diet there must be adequate education of women in regard to the importance of protein both in quantity and quality during these periods of rapid growth and development. Too often women do not care for the protein-rich foods, such as milk, eggs and lean meat, or because of economic circumstances tend to give them to other members of the family. In such instances careful nutritional advice is needed to help them correct their food habits.

Proteins in the diet are derived from both animal and vegetable sources. The animal proteins of meat, milk, eggs, cheese, poultry and fish should form at least 66 percent of the pro-

tein requirements of the pregnant woman, since they furnish all the essential amino acids and are therefore of the highest biologic values. (Studies indicate that the amino acids probably facilitate calcium absorption. The remaining proteins are supplied by vegetables and nuts—such as peanuts and cashews, and legumes, especially soy beans and dried peas and other lentils, and from bread and cereals of whole grain, particularly wheat. Though inadequate sources of certain amino acids, vegetables should be used not only as an accessory source of protein supply but for other essential food factors.

Radio Health Recording Series—A radio recording series entitled "Guardians of Your Health" developed by the American Medical Association for local use through medical societies, health departments and other health agencies is now nearing completion and will be made available for public use August 14, 1945. The series consists of 13 electrically transcribed interviews or round tables describing public health services available to the American people and was prepared under the supervision of the AMA Bureau of Health Education. Included in the series is a program on trained public health personnel presented by Dr. William P. Shepard, third vice-president, Metropolitan Life Insurance Company, San Francisco, and Agnes Fuller, NOPHN. Intended primarily as an educational device for the general public, the script attempts to acquaint the listening audience with public health services available, the special training and qualifications of public health workers, and the scope of their work.

These recordings will be available on a loan basis without cost except return shipping charges to local medical societies or to health departments subject to approval of the local medical society. Radio arrangements must be made locally.

Film-Showing Equipment Study—A study made last year by the Metropolitan Life Insurance Company of film strip equipment in social and health agencies revealed the following:

Of 610 public health nursing agencies interrogated, 506 replied, with 242 stating they used film strip equipment. A breakdown of the figures shows: 25 agencies owned 16mm. silent motion picture projectors; 20, 16mm. sound projectors; 2, 35mm. sound; and none, 35mm. silent.

In a supplementary study undertaken by MLI of film-showing equipment in schools of nursing, figures revealed that motion picture projectors far outnumber film strip and slide equipment and that the 16mm. is the most popular size for both sound and silent motion picture projectors. Of the 1,329 schools of nursing to whom questionnaires were sent, 799 replied. Motion picture projectors were owned by or accessible to the schools as follows:

	Number of Machines Owned	Number of Machines Accessible
35mm. sound	57	42
35mm. silent	22	19
16mm. sound	230	120
16mm. silent	275	105

Study of the film strip projectors revealed: 9 agencies owned the sound type; 37, the silent; 7 agencies had access to the sound type; 14, the silent. Four hundred twenty-six schools owned glass slide projectors; 61 had access to them.

Two agencies owned silent film strip projectors, none owned the sound type. Sixteen owned slides.

Agencies had access to motion picture projectors as follows: 35mm. sound, 49; 35mm. silent, 23; 16mm. sound, 138; 16mm. silent, 80. Sound film strip projectors were accessible to 24 agencies; silent strip projectors to 29. Fifty-six agencies had access to slides.

The Metropolitan's Motion Picture Bureau will be glad to furnish further details regarding its survey to health agencies and schools of nursing. In addition to the survey data, the Bureau has a library of catalogs of motion pictures and film strips covering many subjects available through universities, museums, safety councils, official federal and state departments, industries, et cetera. The Bureau will suggest sources of films on particular subjects to agencies requesting them. For information on this survey of film equipment, the Company's own films, or films available through other sources, write to: Dr. Donald B. Armstrong, second vice-president, Welfare Division, Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, N. Y.

Neuropsychiatric Act—The National Neuropsychiatric Act introduced into Congress as Bill HR 2550 provides for federal grants to states for out-clinic treatment of neuropsychiatric patients. Under it, states could establish out-clinic services that would make it unnecessary for many patients to enter a hospital. The bill also provides for the training of staff. Without such provisions it would be practically impossible to establish clinics.